# CITY OF BALTIMORE

# HEALTH DEPT.

# BUREAU OF

# VITAL STATISTICS

# DEATHS

# BEGINNING 1910

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

# DECLARATION OF INTENT

THE CITY RECORDS MANAGEMENT OFFICER HEREBY DECLARES THAT THE RECORDS MICROFILMED HEREIN, ARE ACTUAL RECORDS OF THE DEPARTMENT OF Health, BUREAU OF Vital Statistics CREATED DURING THE NORMAL COURSE OF BUSINESS AND THAT THE MICROFILM WILL BE INSPECTED TO ASSURE COMPLETENESS OF COVERAGE, AND THAT:

THE MICROFILMING OF THE RECORDS IS ACCOMPLISHED AS PROVIDED FOR IN REQUEST FOR RETENTION PERIOD, AUTHORIZATION NO. 345 AS APPROVED BY THE RECORDS COMMITTEE IN ACCORDANCE WITH ORDINANCE NO. 1096 APPROVED BY THE MAYOR ON JUNE 4, 1954.

FORM RM-1 (11-58) RETAIN—PERM.

Authorization No. 345

Department: Health

Bureau: Vital Statistics

## REQUEST FOR RETENTION PERIOD

To: Records Management Officer,
Room 408, City Hall, Baltimore, 2, Md.

**Record Identification**

| 1. TITLE: | 2. Form No. if available | 3. Type—(cards, paper, etc.) |
|---|---|---|
| Certificate of Death | | Bound Book |

| 4. Dates | 5. Volume accumulated yearly | 6. Size of Record | 7. Number of copies made |
|---|---|---|---|
| | | Misc. | One (1) |

8. Authorization Requested (check only one (1) of the squares below)

A. [ ] Establish retention period for records which are accumulating daily.

B. [ ] Dispose of present accumulation, no additional accumulation anticipated.

C. [ ] Microfilm and destroy originals

D. [X] Microfilm and retain originals for length of time indicated below

| 9. Recommended Retention Period a. In Dept. | b. In Storage Center | c. Total | 10. Equipment and space freed. | 11. In your opinion does this record have any historical significance? |
|---|---|---|---|---|
| 12 yrs. | Micro. Perm. | 12 yrs and Micro. Perm. | | YES [ ] NO [X] |

12. DESCRIPTION OF RECORD: (describe accurately and show recommended retention period.)

These are vital records known as Certificates of Death, required by statute to be registered with the Baltimore City Health Department within several days after the occurrence.

RETENTION PERIOD REQUESTED: Microfilm all Certificates in duplicate retaining the film permanently and store the duplicate rolls of film for security purposes.

Retain original death certificates Twelve (12) years after date of registration, and then destroy after microfilming.

Department or Bureau Approval — Robert E. Farber, M.D. — Title: Commissioner of Health — 3/28/63 Date

**Recommendation of Records Management Officer**

| 13. Recommended Retention Period a. In Dept. | b. In Storage Center | c. Total | 14. Disposal Method A. To be sold as scrap or waste paper | B. To be Burned or shredded | C. Historical, (to be transferred to Dept. of Legislative Reference.) |
|---|---|---|---|---|---|
| 12 yrs. | Microfilm Permanent | 12 yrs. and Microfilm Permanent | [ ] | [X] | [ ] |

REMARKS: 2 negative Rolls

C. P. Force — Records Management Officer — 3/28/63 Date

**APPROVALS OF RECORDS DISPOSAL COMMITTEE**

KINDLY RETURN TO: RECORDS MANAGEMENT OFFICER
ROOM 408, CITY HALL, BALTIMORE 2, MD.

1. APPROVED: CITY AUDITOR

2. APPROVED: CITY SOLICITOR

3. APPROVED: CITY COMPTROLLER

4. APPROVED: CITY TREASURER

5. APPROVED: DIRECTOR, DEPT. OF PUBLIC WORKS

6. APPROVED: DIRECTOR OF THE MUNICIPAL MUSEUM

7. APPROVED: DIRECTOR, DEPT. OF LEGISLATIVE REFERENCE

# FILED ON FILM

# IN

# NUMERICAL ORDER

# NOTICE

The succeeding documents were received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

74-001

E 17561

E 17561 REGISTERED NO.

1 PLACE OF DEATH

City of BALTIMORE: (No. 811 Sterling St. 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia F. Downs.

(a) RESIDENCE NO. 811 Sterling St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Colored | widower |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas E. Downs

6 DATE OF BIRTH (month, day, and year) 1864

| 7 AGE | Years | Months | Days | IF LESS than 1 day ...hrs. or ...min.. |
|---|---|---|---|---|
| 63 | 62 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession of particular kind of work Housework 62

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER George Johnson

11 BIRTHPLACE OF FATHER (city or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Mary Jane Hubbard

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant James Scott

(Address) 811 Sterling St.

15 Filed JAN 5 - 1927 16 Registrar HAMILTON JONES, M. D.

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2 1927

17 I HEREBY CERTIFY, That I attended deceased from 12/31 1926 to Jan 1 1927

that I last saw h... alive on ... 19..

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 4 da.

CONTRIBUTORY (Secondary) General arteriosclerosis

(duration) 4 yrs. mos da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Physician

What test confirmed diagnosis?

(Signed) A. L. Bornstein, M. D.

1/3/27 19 (Address) 733 Augusta St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| National Cemetery | Jan. 6 19 27 |

20 UNDERTAKER ADDRESS

Chas. H. Johnson 416 N. Caroline St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 17562

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129 E. 17562

15-21

1-PLACE OF DEATH

City of BALTIMORE: (No. 1414 N. Mount St. Ward)

REGISTERED No. [redacted]

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henson Gross

(a) RESIDENCE NO. 1414 Mount St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1881

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 46 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) Calvert Co.

(State or country) Md.

PARENTS

10 NAME OF FATHER Richard Gross

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Calvert Co Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Rebecca Gross

(Address) 1414 Mount St

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D.

JAN 5 - 1927 per ..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 12 1926, to Jan 3, 1927, that I last saw him alive on Jan 2, 1927, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Bright's Disease

(Acute Nephritis)

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY

(Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. Wallace Tracy, M. D.

1/3, 1927 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Huntingtown Calvert Co. Date of Burial June 6 1926

20 UNDERTAKER Thos E. Nelson ADDRESS 1303 Pennsylvania

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-3-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17563

E 17563

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St., 7-9 Ward)

2-FULL NAME Francies C. Davis

(a) RESIDENCE NO. Deep Creek & Glass Ave ESSEX Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | white | single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXX

6 DATE OF BIRTH (month, day, and year) Dec 20/26

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | | | 13 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md

PARENTS

10 NAME OF FATHER Joseph L Davis

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Ida B. Buxenstein

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto. Md

14 Informant Joseph L Davis

(Address) Deep Creek Ave

15 Filed JAN 5 - 1927 19 Per K/C Registrar

C. HAMPSON JONES, M. D.

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 Jan 3/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congenital Heart Malformation Brain

(duration) yrs. mos. dy.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. [illegible] Pallen M. D.

(Coroner)

1/5/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery Date of Burial 1/5/ 1927

UNDERTAKER Wm C Millerson ADDRESS 2334 E. Jefferson St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 17564

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17564

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 6-10 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME David Evans

(a) RESIDENCE NO. 116 N. Maderia St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | white | married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Emma E Evans

6 DATE OF BIRTH (month, day, and year) Dec 7/1879

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 47 | 0 | 27 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brick Layer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Maybury Evans

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Susanna Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Emma E. Evans

(Address) 116 N. Madeira St

15 Filed JAN 5 - 1927 C. HAMPSON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 Jan 4/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Frac Base Skull-intra &inter dural Hemorrhage -Struck by automobile (Chester & Fairmount Ave)

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) John W. Pollis, M. D. (Coroner)

1/5/27 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Date of Burial 1/6 1927

20 UNDERTAKER Philip Herring ADDRESS 2016 Orleans

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RICHARD RAY

Cor.—12-9-25—A Co.—200 Bks.

Cor.—12-9-25—A Co.—200 Bks. RICHARD RAY

E 17566

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

100-001

E 17565

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 544 Gold St. St. 14-59 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard Ray

(a) RESIDENCE NO. 544 Gold St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | colored | single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 3, 1926

| 7 AGE | Years | Months | Days | If LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | | 2 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER Samuel Ray

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Tennessee

12 MAIDEN NAME OF MOTHER Lena Ray

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Samuel Ray

(Address) 544 Gold St

15 DEC 5 1927 C. HAMPSON JONES, M. D.

Per [illegible] Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *

(duration) yrs. mos. ds.

(Signed) M. D.
(Coroner)

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Date of Burial Dec. 1927

20 UNDERTAKER Virginia A. Brooks ADDRESS 1603 N. Carey

DEC 5 1927

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17566

## CERTIFICATE OF DEATH.

10-992

E 17566

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham (ST.) Road (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pauline Adams

(a) RESIDENCE NO. 559 Mo ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. 5 mos. 1 ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Fem | Col | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 29 - 1923

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 3 | 4 | 24 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Delaware

PARENTS

10 NAME OF FATHER Walter Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Lassiy Todd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Lassie Adams

(Address) 559 Mo ave

15 Filed JAN 5 1927 19 C. HAMILTON JONES, M. D. Registrar

Per ARN

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1927

17

I HEREBY CERTIFY, That I attended deceased from Dec 24, 1926, to Jan 5, 1927, that I last saw her alive on Jan 5, 1927, and that death occurred, on the date stated above, at 345 P m.

The CAUSE OF DEATH* was as follows:

Tonsillar + Pharyngeal Diphtheria (duration) yrs. mos 17 ds.

CONTRIBUTORY (Secondary) Myocarditis (duration) yrs. mos. 13 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Culture

(Signed) Myron G. Tull, M. D.

1927 (Address) Sydenham Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL 1/8/1927

20 UNDERTAKER Daniel Easton — ADDRESS 1-6 Pratt

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

71-002

E 17567

## CERTIFICATE OF DEATH

E 17568

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. Provident Hospital St. 17-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alberta Washington

(a) RESIDENCE NO. 908 Little Pine St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Black | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 27 1914

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min.. |
|---|---|---|---|---|
| | 12 | 7 | 2 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer) N.D.

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Bath City

PARENTS

10 NAME OF FATHER Geo Washington

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Eva Ballard

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Geo Washington

(Address) 908 Little Pine St

15 1927 C. HAMPSON JONES, M. D. Registrar

For

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927

Jan 4

17 I HEREBY CERTIFY, That I attended deceased from Dec 19, 1926, to Jan 4, 1927.

that I last saw her alive on Jan 4, 1927.

and that death occurred, on the date stated above, at 2.15 p. m.

The CAUSE OF DEATH* was as follows:

Ren-Opthalmic with Meningitis (Chronic)

(duration) yrs. mos 16 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of Dec 20

Was there an autopsy? Diagnosis by eye

What test confirmed diagnosis?

(Signed) R. Cooley, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem. John Wesley Cem. — Date of Burial Jan 7-1927

20 UNDERTAKER Hurst Euston — ADDRESS 916 Pine

5 · OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 17568 HEALTH DEPARTMENT—CITY OF BALTIMORE E 17568.

## CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1. Gwynns Ave. St. 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Obiah Jones

(a) RESIDENCE NO. 1421 W. Lafayette St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): about 1905

7 AGE: Years: 22 Months: Days: IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Wm. Davis

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Va.

PARENTS

10 NAME OF FATHER: John Jones

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Va

12 MAIDEN NAME OF MOTHER: Ann Johnson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Va

14 Informant

(Address): 1421 W. Lafayette St.

15 Filed 19 A. Burial Permit Issued

Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Tuberculosis of Larynx

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) M. D.

(Coroner)

19 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Suffolk Va Date of Burial: Jan 5 19 27

20 UNDERTAKER: Hall & Carson ADDRESS 916 Eq ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JAN 5 1927

C. HAMPSON JONES, M. D.

Spec.—1-12-23—M&T—500 Bks.

E 17569 ✓E 17569

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1725 W. Franklin ST., 14-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Willoughby MacLellan

(a) RESIDENCE NO. 1725 W. Franklin ST., WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. 6 mos. 30 ds. How long in U. S., if of foreign birth? 75 yrs. 6 mos. 30 ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (none)

6 DATE OF BIRTH (month, day, and year) June 5 1851

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 75 | 6 | 30 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Rufus C. MacLellan

11 BIRTHPLACE OF FATHER (city or town) (State or country) ??? New Hampshire

12 MAIDEN NAME OF MOTHER Annie Bartlett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Boston Massachusetts

14 Informant Miss Laura MacLellan (sister)

(Address) 1725 W. Franklin St.

15 5 - 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 4, 1926, to Jan 4, 1927, that I last saw h alive on Jan 4, 1927, and that death occurred, on the date stated above, at 5 00 m.

The CAUSE OF DEATH* was as follows:

Pneumonia Sclerosis of R Lung

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 2 yrs mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No Clinical

What test confirmed diagnosis?

(Signed) John A Evans, M. D.

, 19 (Address) 612 W 40th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL Jan 6 1927

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor)

ADDRESS 108 W. NORTH AVE.

CROSS OF DEATH in plain ink. See instructions on back of certificates. TION is very important

Cor.—12-9-25—A Co.—200 Bks.

E. 17570

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

24001 E 17570

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 210 Mt Holly St. 15-61 Ward)

2-FULL NAME William H. Wright

(a) RESIDENCE NO. 210 Mt Holly St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Euclopede M. Wright

6 DATE OF BIRTH (month, day and year) Dec. 16th 1861

| 7 AGE | Years | Months | Days | IF LESS than 1 day..... hrs. or.....min. |
|---|---|---|---|---|
| | 65 | 0 | 21 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Auditor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B. & O. R.R. Springfield Ohio

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Ezra P. Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mass

12 MAIDEN NAME OF MOTHER Lacey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mass

14 Informant Mrs Joseph Wright

(Address) Cleveland Ohio

15 1927 C. HAMPSON JONES, M. D. Registrar

Per

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4th 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held no (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Arteriosclerosis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs. mos. ds.

(Signed) M. D. (Coroner)

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cleveland, Ohio Date of Burial 1927

UNDERTAKER W. J. Jackson Son & Hendrickson ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

5

Spec.-12-23-21-E.B.R.S.—400 Bks.

E 17571

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17571

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1526 E. Biddle St. 8-13 Ward) 90 Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace C York

(a) Residence No. 1526 E Biddle St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. W.

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 1, 1887

7-AGE. 39 yrs. 8 mos. 3 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town). Chestertown

(State or Country). Md.

PARENTS.

10-NAME OF FATHER. Charles S York

11-BIRTHPLACE OF FATHER (city or town). Balto

(State or Country). Md

12-MAIDEN NAME OF MOTHER. Lillian J Hall

13-BIRTHPLACE OF MOTHER (city or town). Balto

(State or Country). Md

11- (Informant). Charles S York

(Address) 1526 E Biddle St

15- Filed Jan 5 - 1927 C. HAMPSON JONES, M. D. Registrar. Per BRD

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 4, 1927

I HEREBY CERTIFY, That I attended deceased from Jan 2, 1927 to Jan 4, 1927.

That I last saw h. alive on Jan 4, 1927

and that death occurred, on the date stated above, at 11:45 P. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) yrs. mos. ds

CONTRIBUTORY (Secondary) Contributory

(Duration) yrs. mos. 3 ds

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. H. Thomas, M. D.

Jan 5, 1927 (Address) 1228 E Cowlin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Greenmount

DATE OF BURIAL. June 7, 1927

20-UNDERTAKER. W. M. Cook

ADDRESS 503 E Monument

instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17572

17572

## CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 332 S. Monroe ST. 70-28 (WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marion Hark

(a) RESIDENCE NO. 332 S. Monroe ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 4 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Ellen Hark

6 DATE OF BIRTH (month, day, and year) Aug 28, 1869

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 57 | 4 | 3 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Furniture Store

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Geo W Hark

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Harriet Edmonston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs Ellen Hark

(Address) 332 S. Monroe St

15 Filed 1-5 1927 19 Per C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany. 3 1927

17

I HEREBY CERTIFY, That I attended deceased from Nov. 20, 1926, to Jany 3, 1927, that I last saw him alive on Jany 3, 1927, and that death occurred, on the date stated above, at 9.40 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Intestines

(duration) 2 yrs. 1 mos 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. O'Neill M. D.

1/4, 1927 (Address) 108 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL Jan 6th 1927

20 UNDERTAKER Joseph B Cook

ADDRESS 1003 W Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupa-TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17573

E 17573

## CERTIFICATE OF DEATH.

14-001

REGISTERED NO. 10-27

1-PLACE OF DEATH General German Aged Home

City of BALTIMORE: (No. N.E. Cor Baltimore & Payson Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria Buchmeyer

(a) RESIDENCE No. N.E. Cor Baltimore & Payson Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not Known

6 DATE OF BIRTH (month, day, and year) March 28. 1827

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 99 | 9 | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Darmstadt

(State or country) Germany

PARENTS

10 NAME OF FATHER Kaspar Scharch

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Margarethe Raab

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Records German Aged Home

(Address) Baltimore & Payson

15 Filed 1-14, 1927 C. HAMPSON JONES, M. D. (Registrar)

Per APW

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/4/27. 19

17

I HEREBY CERTIFY, That I attended deceased from Jan 3rd, 1927, to Jan 4th, 1927,

that I last saw h.... alive on Jan 3, 1927,

and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John H South, M. D.

1942 N Bath St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pikesville

Date of Burial Jan 6" 1927

20 UNDERTAKER Joseph B. Cook

ADDRESS 1003 N Bath St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

15 - 1927

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17574

## CERTIFICATE OF DEATH.

129 E 17574

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2024 Linden Avenue ST., 13-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie Vickers Barnes

(a) RESIDENCE NO. 2024 Linden Avenue ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct.13,1856

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 70 | 2 | 21 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher 068

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Samuel Nelson Barnes

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Mary Ellen Vickers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore County,Md.

14 Informant Anna Percival Firor
(Address) 1818 W. Susquehanna Ave. Philadelphia, Pa.

15 1/4/27 C. HAMPSON JONES, M. D. Registrar
Per

6 - 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan.4, 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 15th, 1926 to Jan 4th 1927
that I last saw h er alive on Jan 3rd,1927
and that death occurred, on the date stated above, at 1.40 a m.

The CAUSE OF DEATH* was as follows:

Bronchitis, Endocarditis and Chronic Nephritis

(duration) 1 yrs. mos 19 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) — yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical diagnosis

(Signed) S. A. Linthicum M. D.

1/4/27 19 (Address) 1901 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Jan. 6 19 27

20 UNDERTAKER: Joseph B Cook

ADDRESS: 1003 W Balto St

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 17575

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17575

## CERTIFICATE OF DEATH.

1927 129

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace Parkes

(a) RESIDENCE NO. 20 N. Carey St. Balto - ST. ..... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of William Parkes

6 DATE OF BIRTH (month, day, and year) April 17, 1889

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 37 | 8 | 18 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home.

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Mr. Dillow

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Virginia

12 MAIDEN NAME OF MOTHER Edmonie Dillow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Records - JOHNS HOPKINS HOSPITAL

(Address)

15 Filed JAN 5 - 1927 19 C. HAMPSON JONES, M.D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 1927

17

I HEREBY CERTIFY, That I attended deceased from Dec - 11, 1926, to Jan - 4, 1927,

that I last saw her alive on Jan 4, 1927

and that death occurred, on the date stated above, at 6 50 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, hypertension, Myocardial insufficiency - Chronic nephritis, pyelitis

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Milton Sherry, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Lick Branch, West Virginia | Jan. 5 1927 |
| 20 UNDERTAKER Joseph W. Cook | ADDRESS 1003 W. Balto St. |

TION is very important See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17576

E 17576

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Baltimore Eye, Ear, & Throat Hospital ST.: 8-40 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Marie Voyce

(a) RESIDENCE. No. 3014 Emley Ave St. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| F | W | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Howard Voyce

6 DATE OF BIRTH (month, day, and year) Jan 13. 1888

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 38 | 11 | 20 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) S

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Robert E Frazier

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Emma E Bouck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Howard Voyce

(Address) 3410 Elmley Ave.

15 [illegible] 5 - 1927 C. HAMPSON JONES, M. D. Registrar

Per [illegible]

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/3/27 19

17 I HEREBY CERTIFY, That I attended deceased from Dec 30-26, 19 26. to Jan 3, 19 27.

that I last saw h er alive on Jan 3, 19 27.

and that death occurred, on the date stated above, at 3:40 P. m.

The CAUSE OF DEATH* was as follows:

Mastoiditis

(duration) 17 yrs. mon. ds.

CONTRIBUTORY (Secondary) Sinus thrombosis, Septicemia

(duration) yrs. one mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of 12/31/26

Was there an autopsy? yes (of head.)

What test confirmed diagnosis? autopsy, thrombus

(Signed) Sylvan Rosenheim M. D.

1/3/27 19 (Address) 1214 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| London Park Cem. | 1927 |
| 20 UNDERTAKER | ADDRESS |
| Wm Cook | 1002 E. Fay. Ave |

TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Dr. McGarrell - 633 S - 3rd St

E 17577 · HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

96 17577

1-PLACE OF DEATH

City of BALTIMORE: (No. 3602 Fait Ave St. 76-37 Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Alonzo F. Baldwin

(a) Residence No. 3602 Fait Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M

4-COLOR OR RACE, W

5-SINGLE, Married, Widowed, or Divorced, (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Susanna Baldwin

6-DATE OF BIRTH (month, day and year) Jan 17 52

7-AGE, 70 yrs. 11 mos. 23 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) Stationary

(c) Name of employer Baltimore

9-BIRTHPLACE (city or town) (State or Country), Laurel Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore

14- (Informant) Alonzo F. Baldwin

(Address) 3602 Fait Ave

15- Filed 1-6 1927 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 5. 1927

17- I HEREBY CERTIFY, That I attended deceased from 12/30 1926, to 1/5 1927

that I last saw h. alive on 1/4 1927

and that death occurred, on the date stated above, at 2:35 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis - arterio-sclerosis + Apoplexy.

(Duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis?

1/6 (Signed) J. McGarrell M. D.

1927 (Address) 633-S-3rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mary's Hombleton DATE OF BURIAL, Jan 6 1927

20-UNDERTAKER, W. Cook ADDRESS 532 E North Ave

In plain terms, so that it may be properly classified. EASY. Follow instructions on back of certificates.

5

Spec.—6-9-19—H. P. Co.—1000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17578

## CERTIFICATE OF DEATH.

90 E 17578

REGISTERED NO.

1-2

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 139 S. Potomac St. (or WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Wladyslavia (Seamon.) Lizzy Nowowiejski

(a) RESIDENCE. No. 139 S. Potomac St., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alexander Seamon.

6 DATE OF BIRTH (month, day, and year) Mar. 1886.

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 40 yrs. | 10 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) POLAND.

PARENTS

10 NAME OF FATHER Alexander Michalski

11 BIRTHPLACE OF FATHER (city or town) (State or country) POLAND.

12 MAIDEN NAME OF MOTHER Mary Rupinski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) POLAND.

14 Informant Husband. Mr. Alex. Seamon.

(Address) 139 S. Potomac St.

15 Filed 5-1927 C. HAMPSON JONES, M. D. Registrar

Per ECK

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 3/27 19.

17 I HEREBY CERTIFY, That I attended deceased from Oct. 28/26, 19..., to Jan. 3/27., 19...,

that I last saw her alive on Jan. 3/27., 19...,

and that death occurred, on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Endocarditis & Myocarditis

(duration) 1 yr. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) B F Kelly, M. D.

19 (Address) 413 Nat. Marine Bank Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Holy Rosary Cem | Jan 7 1927 |
| 20 UNDERTAKER | ADDRESS |
| John M Weber | 1803 Bank |

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17579 Lowelia 129 E 17579

## CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 315 Poplar Ave (on Jan 7 '27) ST. WARD.

2-FULL NAME Elizabeth Sirk

(a) RESIDENCE. No. 315 Poplar Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? 65 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Sirk

6 DATE OF BIRTH (month, day, and year): July 13 1844

7 AGE: Years 82 Months 5 Days 22 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Harry Peters

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Mrs. Lucy Jones 315 Poplar Ave

15 Filed 5 - 1927 C. HAMPSON JONES, M. D. Registrar

Per ARH

CAUSE OF DEATH to be plainly written, so that it may be properly CODED. TION is very important. See instructions on back of certificates.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 7 - 1927

17 I HEREBY CERTIFY, That I attended, deceased from Dec 12 1926 to Jan 4 1927

that I last saw h.er alive on Jan 4 1927

and that death occurred, on the date stated above, at 2:30 p. m.

The CAUSE OF DEATH* was as follows:

arterial hypertension

arterial Sclerosis

Chr. Nephritis.

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary): Hemiplegia.

(duration) yrs. 1 mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Urin - Blood Sputum &

(Signed) Louis F. Krumrein M. D.

1927 (Address) 722 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem Jan 7 DATE OF BURIAL 1927

20 UNDERTAKER: John C. Miller ADDRESS 2435 E Oliver

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17580

## CERTIFICATE OF DEATH.

E 17580

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1 Mc Dermitt Ct St. B-5 Ward)

2-FULL NAME Henry Conquest

(a) RESIDENCE NO. 1 Mc Dermitt Ct St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 2-1878

7 AGE 48 Years 8 Months 2 Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va

(State or country)

PARENTS

10 NAME OF FATHER Alfred Conquest

11 BIRTHPLACE OF FATHER (city or town) Va

(State or country)

12 MAIDEN NAME OF MOTHER Emma Taylor

13 BIRTHPLACE OF MOTHER (city or town) Va

(State or country)

14 Informant Alfred Conquest

(Address) 917 Mulberry St

15 Filed 5-1927 C. HAMPSON JONES, M. D. Registrar

Per

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 192 27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Alcoholism

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 1 ds.

Jan 6/27 (Signed) G. B. Brady, M. D. (Coroner)

(Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Int. Antrim Cem. Date of Burial 1-7 1927

20 UNDERTAKER: George L. A. Gelson ADDRESS 1735 Druid Hill Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 17581 HEALTH DEPARTMENT—CITY OF BALTIMORE E 17581

CERTIFICATE OF DEATH. 101-001

1-PLACE OF DEATH Baltimore City Hospitals B-4 REGISTERED NO.

CITY OF BALTIMORE: (No. ST. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gene Dinosso

(a) RESIDENCE NO. 401 S. Bond ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs mos ds. How long in U. S., if of foreign birth? 15 yrs mos ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 1 - 1879

7 AGE: Years 47 | Months 8 | Days 4 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Gene Dinosso

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Mrs Rose
(Address) 401 Bank St

15 Filed JAN 5 1927 C. HAMPSON JONES, M. D. Registrar
Per RDD

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1927

17 I HEREBY CERTIFY, That I attended deceased from January 1st, 1927, to Jan 4, 1927, that I last saw him alive on January 4, 1927, and that death occurred, on the date stated above, at 12 45 A M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at 401 S. Bond St

Did an operation precede death? Date of —

Was there an autopsy?

What test confirmed diagnosis? Physical findings

(Signed) Samuel Silverstein M. D.

, 19 (Address) 22 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Vincents — DATE OF BURIAL: Jan 8 1927

20 UNDERTAKER: Kendall Dupper Leton — ADDRESS: 37 S Conn Ave

TION is very important See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17582

## CERTIFICATE OF DEATH

90 ✓ E 17582

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 114 S Castle St. 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph F Wenther

(a) RESIDENCE NO. 114 S Castle St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widower |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret F Wenther

6 DATE OF BIRTH (month, day, and year) March 1852

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 74 | 10 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md

PARENTS

10 NAME OF FATHER Joseph F Wenther

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Margarette Jones

(Address) 114 S Castle

15 Filed JAN 5 1927 C. HANSON JONES, M. D. Registrar

Per LR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 1926 to Jan 4 1927

that I last saw h[illegible] alive on Jan 4 1927

and that death occurred, on the date stated above, at 11 40 P m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart

Trouble

(duration) yrs. 3 mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William Kyzer M. D.

Jan 5 1927 (Address) 801 N Kenwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — Date of Burial Jan 8 1927

20 UNDERTAKER R W Meyer — ADDRESS 1620 Ashburton

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17583

## CERTIFICATE OF DEATH.

129 E 17583

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 705 Forest ST. 10-19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edgar Lucas

(a) RESIDENCE NO. 705 Forest ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | C | Widower |

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Marion Lucas

6 DATE OF BIRTH (month, day, and year) unknown

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | appx 65 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Montgomery Co Md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Marion Sugnet

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Paul Lucas (son)

(Address) 705 Forest St

15 Filed JAN 6 1927 19 Per C. HAMPSON JONES, M. D. Registrar

CAUSE OF DEATH must be filled in all cases. See instructions on back of certificates. TION is very important

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan 1 1927 to Jan 3 1927.

that I last saw h in alive on Jan 3 1927,

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) yrs. mos. 1 wks. ds.

CONTRIBUTORY (Secondary) Severe Bronchitis & Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted (if not at place of death)?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) R J Young M. D.

1/5, 1927 (Address) 1 E Eag & Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery | DATE OF BURIAL Jan 6 1927

UNDERTAKER Jos. I. H. Rochester | ADDRESS 1413 Pa Ave

Spec.—1-12-23—M&T—500 Blks.

E 17584 HEALTH DEPARTMENT—CITY OF BALTIMORE 2E 17584

# CERTIFICATE OF DEATH

1-PLACE OF DEATH — REGISTERED NO. .....

CITY OF BALTIMORE: (No. Arundel Cove St. 25 Curtis Bay Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret A Johnson

(a) RESIDENCE NO. Arundel Cove ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Arch Johnson

6 DATE OF BIRTH (month, day, and year) NOV 16 1854

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 72 | 1 | 16 17 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) at home
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Rock Creek Maryland

PARENTS
10 NAME OF FATHER Allen Williams
11 BIRTHPLACE OF FATHER (city or town) (State or country) St Margaret Maryland
12 MAIDEN NAME OF MOTHER Amanda R Williams
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Marley Maryland

14 Informant Arch Johnson
(Address) Arundel Cove Md

15 JAN 6 - 1927 HAMPSON JONES, M. D. Registrar
For

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec. 10th, 1926, to Jan 4th, 1926, that I last saw h Ex alive on Jan 4th and that death occurred, on the date stated above, at 10 55 A. M.

The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis.
(Uremic Sclerosis.)
(duration) Indefinite mos ds.

CONTRIBUTORY (Secondary) Uremia.
(duration) yrs. mos. 3-4 ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Unimportant
(Signed) John F Hellegandner, M. D.
, 19 (Address) Glen Burnie, B&O Co. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Solley Cemetery A.A. Co. DATE OF BURIAL Jan 7 1927

20 UNDERTAKER D. John F. Denny ADDRESS 715 Light St

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17585

## CERTIFICATE OF DEATH.

E 17585

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md General Hospital ST. 24-35 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Magdaline Hein.

(a) RESIDENCE NO. 1402 Hull ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | W | Married |

5a If married, widowed, or divorced (or) WIFE of O. S. Hein

6 DATE OF BIRTH (month, day, and year) 7-14-1882

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 44 | 5 | 21 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. W 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Nicholas Mulender

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Elizabeth Elstack

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Hospital Records (Address)

15 JAN 6 - 1927 HAMPTON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-5 1927.

17 I HEREBY CERTIFY, That I attended deceased from Dec 17 1926 to Jan 5 1927.

that I last saw h alive on Jan 5 1927.

and that death occurred, on the date stated above, at 1.25 A m.

The CAUSE OF DEATH* was as follows:

Chronic Cholecystitis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia 15-d

Influenza (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? Yes Date of Dec 7-26

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno A Warnekros M.D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross R.C. Cem DATE OF BURIAL Jan 7, 1927

UNDERTAKER Margaret J. Flynn ADDRESS 1422 Light St

CAUSE OF DEATH to print items, if typewriting is used. Please do not write in margins.
TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 17586

# HEALTH DEPARTMENT—CITY OF BALTIMORE

38 E 17586

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1102 Reach al St., 23-31 Ward.) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sadie Randalls

(a) Residence No. 1102 Reach al St., 23 Ward.

(Usual place of abode.)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: F.

4-COLOR OR RACE: Col.

5-Single, Married, Widowed, or Divorced. (Write the word.): married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm Randalls

6-DATE OF BIRTH (month, day and year): autumn

7-AGE: Yrs. 45 mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer): "

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Md.

PARENTS.

10-NAME OF FATHER: unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Va.

12-MAIDEN NAME OF MOTHER: unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Va.

11- (Informant): Wm Randalls

(Address): 1102 Reach al.

15- Filed JAN 6 - 1927 C. HANSON JONES, M. D. Registrar. Per

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 1/4/27

17- I HEREBY CERTIFY, That I attended deceased from 12/23/26 to 1/4/27 that I last saw h alive on 1/3/27 and that death occurred, on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis.

about (Duration) 2 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Hypertrophy of Heart

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Microscopic

(Signed) M. D.

1/5/27 (Address) 1102 Reach St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem. DATE OF BURIAL: Jan 6 1927

20-UNDERTAKER: H. L. Brown's Son ADDRESS 108 W. Monroe St

Instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17587

180-001

## CERTIFICATE OF DEATH.

E 17587

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1712 Carlton St. 17-19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas Budd

(a) RESIDENCE NO. 1712 Carlton St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 da. How long in U. S., if of foreign birth? yrs. mos. da.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Col | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11/19/26

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | | 6 wks | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Charles Dunn

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Norfolk Va.

12 MAIDEN NAME OF MOTHER Ellen Budd

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Byron Wright Undertaker

(Address) 1718 McElderry

JAN 6 - 1927

E. HAMPTON JONES, M. D.

Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3. 27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Asphyxiation Caused by "Coors" on face

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) H. T. Reese, M. D.

(Coroner)

Jan 6, 1927 (Address) 16 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery Date of Burial 1/4/ 1927

20 UNDERTAKER Byron Wright ADDRESS 1718 McElderry

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

E 17588

Hanemann

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129 ✓ E 17588

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1102 W Mulberry St. Ward) 18-26

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Hannon

(a) RESIDENCE NO. 1102 W Mulberry St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | col | Widowed |

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of George Hannon

6 DATE OF BIRTH (month, day, and year) Jan 28, 1886

| 7 AGE Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|
| 40 | 8 | 5 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) Denton

(State or country) Md.

PARENTS

10 NAME OF FATHER Rudolph Cephas

11 BIRTHPLACE OF FATHER (city or town) Denton Md.

(State or country)

12 MAIDEN NAME OF MOTHER Eliza Thomas

13 BIRTHPLACE OF MOTHER (city or town) Denton Md

(State or country)

14 Informant R. E. Webster

(Address) 1102 W Mulberry St.

15 Filed ..... 19 ..... W. HAMPSON JONES, M. D. Registrar

JAN 6 - 1927 Per R M

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1 - 3 - 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec - 3 - 1926, to 1 - 3 - 1927,

that I last saw h.. alive on 1/1/, 1927,

and that death occurred, on the date stated above, at 11:0 A.M.

The CAUSE OF DEATH was as follows:

a Subacute Bacterial Endocarditis

b Nephritis c mitral regurgitation

(duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [illegible] Patterson, M. D.

1/4. 1927 (Address) 1509 Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Com Date of Burial Jan 7 1927

20 UNDERTAKER Samuel Wensley ADDRESS 578 W Baltimore St.

OF DEATH in plain terms, so that it may be properly classified. EXACT SPECIFIC OF OCCUPATION IS very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

JACKSON

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17589

## CERTIFICATE OF DEATH.

E 17589

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1114 N. Mount St. S. 16 22/100-001 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard Jackson

(a) RESIDENCE NO. 1114 N. Mount St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | colored | single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 4, 1924

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | | 1 | 2 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER John Jackson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Minor

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va.

14 Informant Mary Jackson

(Address) 1114 N. Mount St.

Filed JAN 6 - 1927 E. HAMPSON JONES, M. D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) M. D.

(Coroner)

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem Date of Burial Jan 6 1927

20 UNDERTAKER Samuel Hinsley ADDRESS 1528 Edmondson Ave

Of DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17590

## CERTIFICATE OF DEATH.

16-002

E 17590

REGISTERED No. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Homewood Hos. St., 12-51 Ward).

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME (Norman) Baby Daniels

(a) RESIDENCE NO. 117 Wickham Rd St., Lansdowne Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | single |

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 4-1927

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | — | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — (Nil)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER John E Daniels

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Anna Lockwood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Father

(Address)

15 Filed JAN 6 - 1927 C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 4 1927 to Jan 5 1927, that I last saw him alive on Jan 5 1927, and that death occurred, on the date stated above, at 6 4 m.

The CAUSE OF DEATH* was as follows:

Fetal death due to dystocia

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) W. R. Eichen M. D.

1/6, 1927 (Address) 771 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Cedar Hill Cem | 1/6 1927 |
| 20 UNDERTAKER | ADDRESS |
| J. Frew McCully | 130 E Fay |

TION IS very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Pks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 17591 — 1-PLACE OF DEATH

90 / 2863

E 17591 — REGISTERED NO.

City of BALTIMORE: (No. 4217 Fernhill Ave. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Dorothy Keigler

(a) RESIDENCE NO. 4217 Fernhill Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. 5 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 29. 1910

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 16 | 8 | 6 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School girl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm N. Keigler

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Neer

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Arthur Keigler
(Address) 2002 Robb St

C. HAMPSON JONES, M. D.

Filed 1927 Per Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 January 5

17 I HEREBY CERTIFY, That I attended deceased from Jan 1925, to Jan 5, 1927, that I last saw h[illegible] alive on Jan 4, 1927, and that death occurred, on the date stated above, at ½ a m.

The CAUSE OF DEATH* was as follows:

Myositis about 2 yrs
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation of heart
(duration) yrs. mos. 1 ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) for Jos W S Gilbert, M. D.
19 (Address) 2220 Garrison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial
London Park Cem. Jan. 7 1927

20 UNDERTAKER — ADDRESS 1940 W. North Ave
Harry W. Ehlen

Of DEATH in plain terms, so that it may be properly classified. Last statement of OCCUPATION is very important. See instructions on back of certificate.

No. 6 - 1927

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17592

## CERTIFICATE OF DEATH.

31 E 17592

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1629 Druid Hill Av ST. 14-20 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie Hall

(a) RESIDENCE NO. 1629 Druid Hill Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lee W. Hall

6 DATE OF BIRTH (month, day, and year): April 1884

7 AGE — Years: 42 — Months: 8 — Days: 27 — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Thomas Turner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Maria Owen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Lee W. Hall
(Address): 1629 Druid Hill Ave

15 Filed: NO 6 1927 — Registrar: C. HAMPSON JONES, M. D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov. 15, 1926, to Jan. 4, 1927, that I last saw her alive on Jan. 4, 1927, and that death occurred, on the date stated above, at 4.15 P. m.

The CAUSE OF DEATH* was as follows:

Hemmorrhage of Lung
Tuberculosis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): Tuberculosis + Nephritis

(duration) yrs. 7 mos. 6 ds.

18 Where was disease contracted if not at place of death? Prince George Co. Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Postive

(Signed) Dr G W Kennard, M. D.

1-5, 1927 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: 1/7/1927

20 UNDERTAKER: Mrs. Geo. H. Holland — ADDRESS: 1631 Druid Hill

IMPORTANT. See instructions on back

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17593

## CERTIFICATE OF DEATH.

57 E 17593

1-PLACE OF DEATH West Baltimore General Hospital — REGISTERED NO. 1969

CITY OF BALTIMORE: (No. Payne and Dukeland ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Houck

(a) RESIDENCE NO. ~~2503 Emerson St~~ Randallstown, Md. ST. Marriott Lane WARD Rockdale Md.

(Usual place of abode)

Length of residence in city or town where death occurred ~~45~~ yrs. ~~2~~ mos. ~~20~~ 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of or ~~WIFE~~ of Minnie Lages Houck

6 DATE OF BIRTH (month, day, and year) Oct 12th 1881

7 AGE: Years 45 | Months 7 | Days 23 24 | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Conductor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B. & O. R.R.

9 BIRTHPLACE (city or town) (State or country): Balto, Md.

PARENTS

10 NAME OF FATHER: James Houck

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Sarah Gaylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Mrs Minnie Houck 2503 Emerson Ave

15 [illegible] E. HAMPTON JONES, M.D. Registrar

JAN 8 - 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/5 1927

17 I HEREBY CERTIFY, That I attended deceased from 1/3, 1922 to 1/5, 1927, that I last saw h~~im~~alive on 1/5, 1927, and that death occurred, on the date stated above, at 12:25 A. m.

The CAUSE OF DEATH* was as follows:

Diabetic coma

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Acute uremia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Benjamin Miller, M. D.

, 19 (Address) W. B. & A.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem.

DATE OF BURIAL: Jan 7th 1927

20 UNDERTAKER: John F. Cowan & Son per J. F. Cowan

ADDRESS: 401 Holliday

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17594

## CERTIFICATE OF DEATH.

161-0 E 17594

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 5-8 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Boy Allen

(a) RESIDENCE NO. 1408 Orleans St ST., ..... WARD Hlth to

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | C | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 3, 1927

| 7 AGE | Years | Months | Days | If LESS than 1 day, 10 hrs 55 min. |
|---|---|---|---|---|
| | | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ..... Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Walter Jackson

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Hattie Allen

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country)

14 Informant father

(Address) JOHNS HOPKINS HOSPITAL

JAN 6 - 1927 HAMPSON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3 1927

17 I HEREBY CERTIFY, That I attended deceased ~~from~~ on Jan 3, 1927, to ....., 19....., that I last saw h alive on Jan 3, 1927, and that death occurred, on the date stated above, at 10:55 P m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ..... yrs ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs ..... mos ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? yes

What test confirmed diagnosis? Pathological

(Signed) Thomas O'Connell M. D.

, 19 Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL ..... 19.....

UNDERTAKER ..... ADDRESS JOHNS HOPKINS HOSPITAL

Spec—12-23-21—E.B.R.S.—400 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17595

## CERTIFICATE OF DEATH.

E 17595

Registered No. 4

1-PLACE OF DEATH

City of BALTIMORE: (No. 263 West 31st St. 12-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.) Owings Mills Rd

2-FULL NAME Hester E Slade

(a) Residence No. 263 West 31st St. Ward Bon Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F

4-COLOR OR RACE, W

5-CONDITION Married, Widowed, or Divorced, (Write the word.) Wife

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec 26, 1859

7-AGE, 67 yrs. 11 mos. 5 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Md.
(State or Country),

PARENTS.

10-NAME OF FATHER, Louis H Slade

11-BIRTHPLACE OF FATHER (city or town) Md.
(State or Country),

12-MAIDEN NAME OF MOTHER, Hanette Peacock

13-BIRTHPLACE OF MOTHER (city or town) Md
(State or Country),

14- (Informant) Louis H Slade Jr

(Address) 263 W 31st St

15- Filed JAN 6 - 1927 C. HAMPSON JONES, M. D. Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 1, 1927

17- I HEREBY CERTIFY, That I attended deceased from Dec. 27, 1926 to Jan 4, 1927

that I last saw her alive on Jan 4, 1927

and that death occurred, on the date stated above, at 5:00 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Coronary

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C Humpstone, M. D.

1/5, 1927 (Address) 3701 Ruby

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Stone Chapel — DATE OF BURIAL, Jan 7, 1927

20-UNDERTAKER, J. W. Cook — ADDRESS 502 E North Ave

INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.—12-9-25—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17596

## CERTIFICATE OF DEATH

12-49

129 E 17596

REGISTERED NO.

1-PLACE OF DEATH Mercy Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. ____ St. 12-49 Ward)

2-FULL NAME Joseph M Bee

(a) RESIDENCE NO. 1101 N. 39th St Baltimore Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ariel C McBee

6 DATE OF BIRTH (month, day, and year): March 4, 1853

7 AGE: Years 73. Months 10 Days 1 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired School Teacher

(b) General nature of Industry, business, or establishment in which employed (or employer): 068

(c) Name of employer

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER: Wilson O McBee

11 BIRTHPLACE OF FATHER (city or town): Scotland

(State or country)

12 MAIDEN NAME OF MOTHER: Mary Colt

13 BIRTHPLACE OF MOTHER (city or town): Wales

(State or country)

14 Informant: Lee L McBee

(Address): 107 E Saratoga St Towson Md

15 Filed ____ 19 ____ HAMPSON ____ Registrar

Per ____

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 5 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec. 26, 1926, to Jan 5, 1927, that I last saw h— alive on Jan 5, 1927, and that death occurred, on the date stated above, at 6 45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D Martin, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Date of Burial: Jan 8 1927

20 UNDERTAKER: Wilson Cook ADDRESS: 502 E Lafayette Ave

JAN 5 - 1927

Very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 17597 HEALTH DEPARTMENT—CITY OF BALTIMORE E 17597

CERTIFICATE OF DEATH. 90

1-PLACE OF DEATH

CITY OF BALTIMORE; (No.) W. Hamilton ave ST., 77-43 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Bacigalupo

(a) RESIDENCE NO. W. Hamilton ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bacigalupo Lorenzo Bacigalupo

6 DATE OF BIRTH (month, day, and year) Oct 4th 1865

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 61 | 3 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Luigi Bacigalupo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Mary Casacia

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Tom Giannaccini

(Address) Hamilton ave

Filed 1927 C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 4, 1927.

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1926. to Jan. 4, 1927.

that I last saw h alive on Dec. 31, 1926.

and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) yrs. 3 mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. L. Pesonguo M. D.

1.5.27 (Address) 514 Drury Lane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral DATE OF BURIAL Jan 8th 1927

20 UNDERTAKER Frank V. Siburt ADDRESS 2817 E. Baltimore

N6

TION is very important See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 17598

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 17598
Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1226 Hull St. Ward) 24-35 760

2-FULL NAME. William J. Hauser

(a) Residence No. 1226 Hull St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): Jan. 31. 26

7-AGE. yrs. 11 mos. 4 ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town). (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER: Austin Hauser

11-BIRTHPLACE OF FATHER (city or town). (State or Country): Baltimore Maryland

12-MAIDEN NAME OF MOTHER: Marie Nelson

13-BIRTHPLACE OF MOTHER (city or town). (State or Country): Baltimore

14- (Informant): Mrs. Hauser
(Address) 1226 Hull

15- Filed JAN 5 - 1927 Per [illegible] Registrar

C. HAMPSON JONES, M. D.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Jan 5 1927

17- I HEREBY CERTIFY, That I attended deceased from Oct. 22 1926 to Jan. 5 1927 that I last saw her alive on Jan 4 1927 and that death occurred, on the date stated above, at m. The CAUSE OF DEATH* was as follows:

Marasmus - (Duration) yrs. 2 mos. 13 ds

CONTRIBUTORY (Secondary) Contracted Exhaust / (Duration) yrs. mos. ds

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Hauser M.

(Address) 806 N. Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL, 1927: Jan. 6

20-UNDERTAKER: Chas. L. Stearns — ADDRESS: 1501 E Fort Ave.

Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 17599

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

40 E 17599

REGISTERED NO. 15-63

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4507 Liberty Heights St. (WARD)

2-FULL NAME Mary Isabelle Hunlock

(a) RESIDENCE NO. 3806 Barrington Road ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE W.

5 ~~Single~~, Married, Widowed, or ~~Divorced~~, (write the word) Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elmer E Hunlock

6 DATE OF BIRTH (month, day, and year) Feb 6 1865

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 61 | 10 | 29 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John W Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary E Hunlock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Port Deposit Md

14 Informant Elmer E Hunlock

(Address) 3806 Barrington Road

15 Filed JAN 8 - 1927 By C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5th 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 30, 1926, to Jan 5 1926.

that I last saw h alive on Jan 5 1926

and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema & Acute Dilatation of Heart

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation of Heart

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Auscultation

(Signed) A. C. Lemmon, M. D.

1927 (Address) 4509 Liberty Hgts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL Jan 8th 1927

20 UNDERTAKER Putnam & Hoke

ADDRESS 1223 W Baltimore St

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 17600 HEALTH DEPARTMENT—CITY OF BALTIMORE E 17600

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 634 George (ST.) 17-24 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Victoria Handy

(a) RESIDENCE NO. 634 George ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced. (Write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. Handy

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE 51

| Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|
| 50 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Thos A Handy (Address) 4137 Auchentoroly

15 Filed 19 Registrar C. HAMPSON JONES, M. D.

JAN 6 - 1927 per RRK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov. 20, 1926 to Jan. 3 1927

that I last saw her alive on Jan 3, 1927

and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Carcinomatosis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes Pathological findings

What test confirmed diagnosis?

(Signed) W. J. Cark [illegible], M. D.

Jan 3 1927 (Address) 515 Mother

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem DATE OF BURIAL Jan 6 27

20 UNDERTAKER Samuel Kinsley & Bodie ADDRESS 538

TION is very important. See instructions on back of certificate

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17601 ✓ X 129 E 17601

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Maryland Gen. Hosp

CITY OF BALTIMORE: (NO. M ST. 11 WARD) 24

2-FULL NAME Mrs. Edward Wonn

(a) RESIDENCE NO. 508 Baltimore ST., Towson Md.
(Usual place of abode) (If non-resid at give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs E. Wonn

6 DATE OF BIRTH (month, day, and year) Feb. ? 1866

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 60 | 11 | 2 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook 0801

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington DC.

PARENTS

10 NAME OF FATHER William Wonn.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Melinda Executor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hospital Record
(Address)

15 Filed Dec 16 - 1927 Mrs Edna Wonn Jones, M.D. HARPER Parkway Towson Registrar By Harper

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5. 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 17. 1926. to Jan 6. 1927.

that I last saw him alive on Jan 6. 1927.

and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial nephritis
Chronic myocarditis
hypertension.
(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Chronic myocarditis
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? no. Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical.

(Signed) H. A. Thompkins M. D.

19 (Address) 1811 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Glenwood Cem. Washington

DATE OF BURIAL Jan. 8 1927

UNDERTAKER W. M. Fleckner Sons

ADDRESS North Pa

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17602

## CERTIFICATE OF DEATH.

E 17602

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 921 N. Appleton St. 16-22 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence W. Schooley

(a) RESIDENCE. No. 921 N Appleton ST.. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 12 1848

7 AGE — Years: 78 Months: 9 Days: 23 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER Wm H. Schooley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER Hannah Stocks

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Mrs. Effie Schooley

(Address) 921 N Appleton St

15 Filed , 19 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1927

17

I HEREBY CERTIFY, That I attended deceased from December 30 1926. to January 5. 1927.

that I last saw her alive on January 5 . 1927

and that death occurred, on the date stated above, at 12 : 00 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral haemorrhage (apoplexy)
Hemi-plegia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Hypostatic pulmonary
Oedema (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. exam.

(Signed) Darius Daggett M. D.

1/6 . 1927 (Address) 1015 Monroe St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Friend's Cem. Hartford Rd. DATE OF BURIAL: Jan 8 1927

20 UNDERTAKER: Wm J Tickner Sons ADDRESS: North Ave

JAN 6 - 1927 C. HAMPSON JONES, M.

Spec.—12-9-25—A Co.—200 Bks.

Sousa Souris

# HEALTH DEPARTMENT—CITY OF BALTIMORE

129 E 17603

E 17603

## CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Mercy Hospital

City of BALTIMORE: (No._____ St._____ Ward) 4-7

2-FULL NAME William Sousa

(a) RESIDENCE NO. 406 Hanover Alley St._____ Ward_____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21st yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | Colored | Married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1855

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 76 | | | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Hospital Employee
(b) General nature of industry, business, or establishment in which employed (or employer) Employee
(c) Name of employer

9 BIRTHPLACE (city or town) Unknown
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Hospt Record
(Address)

15 Filed JAN 6 - 1927 L. HARRISON JONES, M. D. Registrar
Per _____

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 - 1927.

17 I HEREBY CERTIFY, That I attended deceased from ~~Jan Dec 28~~, 19~~27~~, to Jan 5, 1927, that I last saw him alive on Jan 5, 1927, and that death occurred, on the date stated above, at 4.45 P. m.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis
Arteriosclerosis

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) Cardiac Degeneration

(duration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted
If not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) [illegible], M. D.
, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Date of Burial 1/7, 19 27

20 UNDERTAKER Shirley Fulton ADDRESS 1 Fayette

Duplicate for the use of undertakers. Fill out all items carefully. Be sure to sign certificate in ink. Every question must be answered. Use "unknown" if information cannot be obtained. Use "none" where necessary. Be very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

Howlette · Howlette ✓

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17604

## CERTIFICATE OF DEATH

X 38

REGISTERED NO. E 17604

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hosp 44-20 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Winston Howlette

(a) RESIDENCE NO. 1531 Mc Cullough St. Ward Virginia

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S. if of foreign birth? yrs. 9 mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: C

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Susan Howlette

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE 31 Years — Months — Days. IF LESS than 1 day ___ hrs. or ___ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sailor

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer

9 BIRTHPLACE (city or town) Va

(State or country)

PARENTS

10 NAME OF FATHER James Howlette

11 BIRTHPLACE OF FATHER (City or town) Va

(State or country)

12 MAIDEN NAME OF MOTHER Amanda Smith

13 BIRTHPLACE OF MOTHER (city or town) Va

(State or country)

14 Informant Susan Howlette

(Address) 1531 Mc Cullough St

15 JAN 6 - 1927 T. THAMPSON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-4 1927.

17 I HEREBY CERTIFY, That I attended deceased from 12-31-, 1926, to 1-4-, 1927, that I last saw him alive on 1-4-, 1927, and that death occurred, on the date stated above, at 8-05 A. m.

The CAUSE OF DEATH* was as follows:

Edema of glottis 24 hrs

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Bilateral Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab.

(Signed) J. Hulls Phillips M. D.

(Address) 1122 N Mount St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Suffolk Va — Date of Burial Jan 6 1927

20 UNDERTAKER Jno R A Elliott — ADDRESS Oakland

Of DEATH in plain terms, so that it may be properly very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17605

## CERTIFICATE OF DEATH.

188-003

E 17605

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital St. 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rose Sweeney

(a) RESIDENCE NO. 213 S. Castle St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | white | single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) June-1861

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 05 | 6 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md

PARENTS

10 NAME OF FATHER Dennis Sweeney

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Carr

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Marie Davis

(Address) 1619 Clifton Place

15 Filed JAN 6 1927 Per C. HAMPSON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Concussion
Fractured Clavicle & ribs
Struck by Automobile North Ave
nr Broadway (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. H. Bales M. D.
(Coroner)

1/4/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem. Date of Burial: Jan 7 1927

20 UNDERTAKER: Lilly & Zeiler ADDRESS: 403 S. Wolfe St.

Very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 17606

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17606

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 702 N. Curley ST., 7-12 WARD)

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Centa Vanura

(a) RESIDENCE No. 702 N. Curley ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Vanura Nee Kroon

6 DATE OF BIRTH (month, day, and year) Not Known

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min |
|---|---|---|---|---|
| | 67 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Restaurant Keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Joseph Vanura

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant August Kleiba

(Address) 849 N Collington Ave

JAN 6 - 1927

HAMPSON JONES, M. D.

Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 5 1927

17

I HEREBY CERTIFY, That I attended deceased from Dec. 21, 1926, to Jan. 5, 1927,

that I last saw h[illegible] alive on Jan. 5, 1927

and that death occurred, on the date stated above, at 1.15 P. m

The CAUSE OF DEATH* was as follows:

Suppression of urine

Chronic nephritis

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) arteriosclerosis, myocarditis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed djagnosis?

(Signed) L. C. Gobilal, M. D.

, 19 (Address) 447 N. Kenwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Loudon Park Cemetery | Jan 7 1927 |
| UNDERTAKER | ADDRESS |
| Frank E. Enoch & Son | 1910 Eutaw Place |

TION is very important See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17607

## CERTIFICATE OF DEATH.

31 E 17607

REGISTERED NO. _____

1-PLACE OF DEATH

City of BALTIMORE: (No. 1506 Myrtle Av St. 14-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jas. Thos. McSherry

(a) RESIDENCE NO. 1506 Myrtle Ave St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred _____ yrs. _____ mos. 6 ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) about 1871

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| About | 55 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work unknown

(b) General nature of industry, business, or establishment in which employed (or employer) 087

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) unknown

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country)

14 Informant N. W. Dist Police

(Address) Penna Ave

Filed 1927 Per 19 C. HAMPSON JONES, M. D.

Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29, 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry thereon and from the evidence obtained by said inquiry find that said deceased came to his death on the day stated above.

(Inquest, autopsy or inquiry.)

The CAUSE OF DEATH* was as follows:

Probable Tuberculosis

unknown (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) _____ (duration) ....yrs. ....mos. ....ds.

(Signed) J. T. Hennessy M. D.

(Coroner)

Dec. 31, 1924 (Address) 2802 Edmondson Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery Date of Burial 1/7 1927

20 UNDERTAKER Chas. S. Ward & Son ADDRESS 1810 North Royal Ave

very important. See instructions on back of certificate.

6

THE MORGUE

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 17608

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17608

## CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 656 Dumbarton Ave ST.: WARD: 9-47

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis J. McLaughlin

(a) RESIDENCE. No. 656 Dumbarton Ave ST.: WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna M. McLaughlin

6 DATE OF BIRTH (month, day, and year): Jan 16 1893

7 AGE: Years 34 Months 11 Days 20 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Garage Owner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Phila. Pa

PARENTS

10 NAME OF FATHER: Charles McLaughlin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Ellen Carney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Anna M. McLaughlin 656 Dumbarton Ave

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per R.R.H.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jany 5 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 14 1926 to Jany 5 1927

that I last saw him alive on Jany 5 1927

and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Intermittent

(duration) yrs. 2 mos. 22 ds.

CONTRIBUTORY (Secondary): Ac. Dilation Heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Urinary & Hypostasis

(Signed) Jas L. Horner, M. D.

1-6, 1927 (Address) 962 W. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: 1/8/27

20 UNDERTAKER: Chas. R. Evans & Son

ADDRESS: 118 W. Mt. Royal Ave

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 17609 **HEALTH DEPARTMENT—CITY OF BALTIMORE** E 17609

## CERTIFICATE OF DEATH.

185

1-PLACE OF DEATH Home for Incurables

CITY OF BALTIMORE: (No. Cedar Ave & 40th St., 13 Ward) REGISTERED NO. 13-52

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Bettie Taylor Haskell

(a) RESIDENCE NO. Home for Incurables St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 12, 1851

| 7 AGE Years | Months | Days | If LESS than 1 day, ....hrs. or ....min. |
|---|---|---|---|
| 75 yrs | 2 | 23 & 14 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER John H Haskell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Connecticut

12 MAIDEN NAME OF MOTHER Crawford Reid

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Mrs Jas Haskell

(Address) 103 W. Monument St

15 1927 C. HAMPSON JONES, M. D. Registrar

Per —

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1927

17 I HEREBY CERTIFY, That I attended deceased from 10-11-26, 1926, to 1-5-, 1927.

that I last saw he alive on 1-4-, 1927.

and that death occurred, on the date stated above, at 11.30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Arteriosclerosis-

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Fracture of Femur

(duration) yrs. 06 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. B. Magruder, M. D.

1/14, 1927 (Address) Baltimore Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL Jan 7 1927

20 UNDERTAKER John B Spence — ADDRESS 1325 N Caroline St

TION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17610

E 17610

## CERTIFICATE OF DEATH.

90

REGISTERED NO. _____

1-PLACE OF DEATH

City of BALTIMORE: (No. 1420 Parrish St. 15-21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Rebecca Barrett Hughes

(a) RESIDENCE NO. 1420 Parrish St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Colored | Married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Fountain Hughes

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 57 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md.

PARENTS

10 NAME OF FATHER Joseph Bowen

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country) Md.

12 MAIDEN NAME OF MOTHER Marie Appleberry

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md.

14 Informant Annie E. Gray

(Address) 1810 Eldon St

15 Filed _____ 19 _____ _____ Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 15 1926 to Jan 4 1927, that I last saw h alive on Jan 4 1927, and that death occurred, on the date stated above, at 11.20 P m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) _____

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) E. William Tenney, M. D.

1/6, 1927 (Address) 1728 Pa Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — Date of Burial: Jan 7 1927

20 UNDERTAKER: Daniel Easton — ADDRESS: 5 & ave

Or death in the home, or that it may be very important. See instructions on back of certificates.

Spec—12-23-21—E.B.F.S.—400 Bks.

E 17611

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17611

## CERTIFICATE OF DEATH.

31

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 18 Ridgecroft Rd St. 27-41 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia D. Heilman

(a) Residence No. 18 Ridgecroft Rd St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank A. Heilman

6-DATE OF BIRTH (month, day and year): 6/25/07

7-AGE. 19 yrs. 6 mos. 10 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto. Md.

PARENTS

10-NAME OF FATHER: Joseph Urban

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Rheco Slovakia

12-MAIDEN NAME OF MOTHER: Dorothy Raday

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Rheco Slovakia

14- (Informant): Frank A. Heilman

(Address): 18 Ridgecroft Rd

15- Filed 1926 - 1927 C. HAMPSON JONES, M. D. Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 1/4/27

17- I HEREBY CERTIFY, That I attended deceased from December 23 1926 to Jan. 4 1927

that I last saw her alive on Jan. 3 1927

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

not determined Duration yrs. mos. ds.

CONTRIBUTORY (Secondary) Endocarditis (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Benj. D. Hayden M. D.

1/6/ 1927 (Address) 1716 N. Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Jan 7 1927

20-UNDERTAKER: Leonard J. Ruck — ADDRESS: Sefton Line

INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.—12-9-25—A Co.—200 Bks.

E 17612

# HEALTH DEPARTMENT--CITY OF BALTIMORE

92 E 17612

## CERTIFICATE OF DEATH.

8-17

1-PLACE OF DEATH

City of BALTIMORE: (No. 1534 N. Broadway St. Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Heinz

(a) RESIDENCE NO. 1534 N. Broadway St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Ella L. Heinz

6 DATE OF BIRTH (month, day, and year) Dec. 25. 1861

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 65 | | 10 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Secretary of

(b) General nature of industry, business, or establishment in which employed (or employer) Mf'g. Bitters

(c) Name of employer C. W. Abbott Co.

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER Andrew Heinz

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Mehring

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Ella L. Heinz

(Address) 1534 N. Broadway

15 Jan 7 1927 C. HAMPSON JONES, M. D.

Per Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 4 19 27

17 I HEREBY CERTIFY, That I attended deceased from Dec. 7, 1926, to Jan 4, 1927

that I last saw h~~im~~ alive on Jan 4, 1927

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Endarteritis of Popliteal & Tibial arteries of Right leg.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Thrombosis, Gangrene Terminal Septicaemia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar P. Endrock, M. D.

, 19 (Address) 15 W. Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Druid Ridge Cemetery Jan. 7 1927

20 UNDERTAKER ADDRESS

Wm. C. Black 927 N. Broadway

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17613

## CERTIFICATE OF DEATH.

E 17613

1-PLACE OF DEATH Mercy Hospital REGISTERED NO. 15-68 57

City of BALTIMORE: (No. ____ St. ____ Ward ____)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Helena Morris

(a) RESIDENCE NO. 1733 Ruxton Ave St. ____ Ward ____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 Color or Race White

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE Morris Morris

6 DATE OF BIRTH (month, day, and year) Oct. 15 1851

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 75 | 2 | 20 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Myer Jacobs

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Mina

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs. G. Rosenheim

(Address) 1730 Ruxton Ave.

15 Filed 1927 C. HAMPSON JONES, M. D.
Per ____ Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 - 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 4 1927, to Jan 5, 1927

that I last saw h[illegible] alive on Jan 5 1927

and that death occurred, on the date stated above, at 3.45 P.M.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Gangrene Rt foot

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) S Morta, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Brooklyn, N. Y. Date of Burial 1/7/1927

20 UNDERTAKER David Sondheim ADDRESS 115 20 W. Mt. Royal Ave

Use typewriter or pen and ink; if latter, write plainly and use ink that will not fade. See instructions on back of certificates.

MADISON AVE & CLOVERDALE ROAD.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

17614 — 100-001 — L 17614

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Temple Garden Apts. St., 59 WARD) 10-59

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph M. Zamoiski

(a) RESIDENCE NO. Temple Garden Apts. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Tena B. Zamoiski

6 DATE OF BIRTH (month, day, and year) Feb. 14, 1858

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 68 | 11 | 22 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrical sup

(b) General nature of industry, business, or establishment in which employed (or employer) plies & Radios.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) London, England.

PARENTS

10 NAME OF FATHER Jacob Zamoiski

11 BIRTHPLACE OF FATHER (city or town) (State or country) England.

12 MAIDEN NAME OF MOTHER Sarah Jacobs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England.

14 Informant Mrs. Cabrin Zamoiski

(Address) Temple Golden Apts.

15 1927 C. HAMPSON JONES, M. D.

Ref. C.R.B. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany. 6 1927.

17 I HEREBY CERTIFY, That I attended deceased from Dec. 31, 1926 to Jan. 6 1927.

that I last saw him alive on Jan. 5 1927.

and that death occurred, on the date stated above, at 1.45 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Charles A. Gutman, M. D.

1927 (Address) 1417 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Balt. Hebrew Cem. | 1/9/1927. |
| 20 UNDERTAKER | ADDRESS |
| David Sondheim | 118-20 W. Mt. Royal Ave. |

TION is very important. See INSTRUCTIONS ON BACK OF CERTIFICATE

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17615

E 17615

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2856 Raynor ave St., 16-68 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Lewis

(a) RESIDENCE No. 2856 Raynor Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) Feb 10 1839

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 86 | 11 | 23 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER William Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant John Merrill

(Address) 2856 Raynor

Filed 16 1927 C. HAMPSON JONES, M. D.,

By Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 18, 1926, to Jan 4, 1927.

that I last saw h[illegible] alive on Jan 4, 1927.

and that death occurred, on the date stated above, at 7 20 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) four yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) M Bowmanstool, M. D.

1/6, 1927 (Address) 626 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Loudon Park | Jan 7 1927 |
| 20 UNDERTAKER George J Smith | ADDRESS 1532 Hollins |

TION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 17616

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

90 E 17616

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 14 S. Carrollton Ave St. 18-28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Cathrin Watts

(a) RESIDENCE NO. 14 S Carrollton Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of John Watts

6 DATE OF BIRTH (month, day, and year) March 27, 1874

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min.. |
|---|---|---|---|---|
| | 52 | 9 | 28 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) not

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Lawrence Keating

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant John Watts

(Address) 14 S Carrollton Ave

15 Filed 6-1927 Per R R H C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/4/27 19

17 I HEREBY CERTIFY, That I attended deceased from 12/20/26 to 1/4/27 19

that I last saw her alive on 1/4/27 19

and that death occurred, on the date stated above, at 6 A.M. P. m.

The CAUSE OF DEATH* was as follows:

Hypertension

Myocarditis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) C. Hampson Jones M. D.

1/5/ 19 27 (Address) 9 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — Date of Burial Jan 7 1927

20 UNDERTAKER George J Smith — ADDRESS 1532 Hollins

very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17617 E 17617

## CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

REGISTERED NO. 46-68

CITY OF BALTIMORE: (No. 2723 Riggs Ave WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise M Smith

(a) RESIDENCE. NO. 2723 Riggs Ave WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7½ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 19 1894

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 32 | 9 | 17 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER George Haschert

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Landrigan

13 BIRTHPLACE OF MOTHER (city or town) Penna.
(State or country)

14 Informant James F. Smith
(Address) 2723 Riggs Ave

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1927

17 I HEREBY CERTIFY, That I attended deceased from March 1925. to Jan 5 1927.

that I last saw h[illegible] alive on Jan 4 1927.

and that death occurred, on the date stated above, at 2130 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis Endocarditis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical Findings

(Signed) Geo. R. Wrang, M. D.

, 19 (Address) 4000 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Loudon Park | Jan 8 1927 |
| 20 UNDERTAKER George J. Smith | ADDRESS 1537 Hollins |

FOR IS very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17618

CERTIFICATE OF DEATH.

E 17618

1-PLACE OF DEATH St Joseph Hospital

CITY OF BALTIMORE: (No. Caroline & Oliver St., 16-41 WARD)

REGISTERED NO. 118

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Adell. V. Burton.

(a) RESIDENCE NO. 201 Tipple Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | white | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Reese E. Burton

6 DATE OF BIRTH (month, day, and year) Dec 12, 1902

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 24 | | 24 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) N. Carolina.
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Reese E Burton
(Address) 201 Tipple Ave

15 Filed JAN 6 1927, 19 Per AKA Registrar

C. THAMPSON JONES M.D.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 24, 1926, to Jan 5, 1927, that I last saw h[illegible] alive on Jan 5, 1927, and that death occurred, on the date stated above, at 6:40 a m.

The CAUSE OF DEATH* was as follows:

General Peritonitis - Ileus

CONTRIBUTORY (Secondary) Bronchio Pneumonia (duration) yrs. mos 12 ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of Dec 24-26

Was there an autopsy? none

What test confirmed diagnosis? Clinical

(Signed) F. L. McAnally, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Loudon Park | Jan 8 1927 |

20 UNDERTAKER George J. Smith ADDRESS 1082 Hollins

FOR EVERY REPORTABLE DEATH REGISTERED OR BURIED

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002

E 17619

E 17619

## CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor St. 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna M. Peters

(a) RESIDENCE NO. President Valley St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| F | W | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| about | 75 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 600

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER John Peters

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Delahunt

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Little Sisters of the Poor

(Address)

Filed ..... 19 C. HAMPSON JONES, M. D.

Registrar

NT - 1927

By .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 Jan. 5th

17 I HEREBY CERTIFY, That I attended deceased from first and ....., 19....., to ....., 19.....,

that I last saw her alive on January 2, 1927,

and that death occurred, on the date stated above, at 8.30 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Unknown (duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY .....

(Secondary)

..... (duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. C. Warner, M. D.

Jan 6, 1927 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount

Date of Burial Jan 7 1927

UNDERTAKER Rida Weedon

ADDRESS 914 Guilford

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 17620 HEALTH DEPARTMENT—CITY OF BALTIMORE E 17620

CERTIFICATE OF DEATH.

11-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1017 Race ST. 23 WARD) 23-31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hester Bailey

(a) RESIDENCE NO. 1017 Race ST. 23 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) [redacted] 1[redacted]

7 AGE: Years 58; Months —; Days —; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Accomac Co Va (State or country)

PARENTS

10 NAME OF FATHER Isaac Richs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Margaret —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Edna Martin (Address) 1017 Race St

Filed JAN 7 - 1927 Per HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1927

17 I HEREBY CERTIFY, That I attended deceased from 12/21/26, to 1/5/27, that I last saw h[er] alive on 1/5/27, and that death occurred, on the date stated above, at 11.55 00 m.

The CAUSE OF DEATH* was as follows:

Influenza

Bac. of Influenza

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) Chronic Rheumatism

Paralysis (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) [redacted], M. D.

, 19 (Address) [redacted]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Onancock. Accomac Co. Va

DATE OF BURIAL: Jan 7 1927

20 UNDERTAKER: John W. Toadvine

ADDRESS 1027 Druid Hill

TION is very important. See instructions on back of certificates.

# NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

Cor.—1-12-23—M&T—100 Bks.

E 17621 HEALTH DEPARTMENT—CITY OF BALTIMORE E 17621

CERTIFICATE OF DEATH. 187-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Fort McHenry ST. 4 WARD

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number. If U. S. Soldier, Sailor or Marine, fill out No. 18.)

2-FULL NAME Frank Kobus

(a) RESIDENCE NO. 700 S Durham ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? 19 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Kobus

6 DATE OF BIRTH (month, day, and year) ~~Oct 10 1889~~ Mar 15 1898

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 28 | 9 | 26 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stevedore
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER John Kobus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Kobus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mary Kobus (Address) 700 S Durham st

15 Filed JAN 7 - 1927 C. HAMPTON JONES, M. D. Registrar BY R K

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said ... find that said deceased came to ... death (by autopsy or inquiry.) on the day stated above.
The CAUSE OF DEATH* was as follows: Acute Alcoholism
Contused Abdomen
(duration) yrs. mos ds.
CONTRIBUTORY (Secondary) Shock
(duration) yrs. mos. ds.
(Signed) (Coroner) M. D.
192 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence ...

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Holy Rosary | Jan 8 192 7 |
| 20 UNDERTAKER | ADDRESS |
| George A Weber | 2205 Bank st |

Spec—12-23-21—E.B.R.S.—400 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

17622

## CERTIFICATE OF DEATH.

100-001 E 17622

1-PLACE OF DEATH

Registered No. 1257

City of BALTIMORE: (No. 1004 Grandview Ave St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta C Davis

(a) Residence No. 1004 Grandview Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, Divorced. (Write the word.) Married

5a-If married, widowed, or divorced ~~HUSBAND~~ (or) WIFE of George A Davis

6-DATE OF BIRTH (month, day and year) Jan 6-1846

7-AGE. 80 yrs. 11 mos. 26 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. at Home

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Balto City

PARENTS.

10-NAME OF FATHER. Charles Joshande

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Not known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Not known

14- (Informant) Mr Eugene Davis

(Address) 1004 Grandview Ave

15- Filed JAN 7 - 1927 C. HAMPSON JONES, M. D. Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 6, 1927

17- I HEREBY CERTIFY, That I attended deceased from Jan. 5, 1927 to Jan. 6, 1927

that I last saw h. alive on Jan. 5, 1927

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Edema

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical sign

(Signed) Frank H Hurd, M. D.

, 19 (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Olivet Cemetery DATE OF BURIAL. Jan 8, 1927

20-UNDERTAKER. A R Marshall ADDRESS 3539 Falls Road

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17623

## CERTIFICATE OF DEATH.

E 17623

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1710 N Central Ave ST. 9-18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma H Warwick

(a) RESIDENCE NO. 1710 N Central Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles C Warwick

6 DATE OF BIRTH (month, day, and year) May 12 1900

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 26 | 7 | 22 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Joseph L Hammel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore.

12 MAIDEN NAME OF MOTHER Annie Brennan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Charles C Warwick

(Address) 1710 N Central Ave

15 Filed JAN - 1927 C. HAMPSON JONES, M. D. Registrar

Reg. No. 10

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 10, 1926, to Jan 7, 1927, that I last saw her alive on Jan 7 1927, and that death occurred, on the date stated above, at 6 28 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation (occuring during labor - patient was aborting at 6th month of pregnancy (duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Chr Endocarditis & Mitral Insufficiency (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Wm. H. Paca M. D.

1/5, 1927 (Address) 777 - Saint Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Int Carmel — DATE OF BURIAL Jan 7 1927

20 UNDERTAKER John Merrick — ADDRESS 201 Orleans

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17624

## CERTIFICATE OF DEATH.

90 E 17624

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1717 ~~Ashburton~~ St. 15 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dina Markowitz

(a) RESIDENCE NO. 1717 Ashburton St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jonas Markowitz

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 62 — Months: — — Days: — — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Abraham Tanchaum

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Chandal Seidenschlag

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jonas Markowitz

(Address): 1717 Ashburton St.

15 Filed JAN 7 1927 19 HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 6 1927

17 I HEREBY CERTIFY, That I attended deceased from June 17th, 1925, to Jan. 6th, 1927.

That I last saw her alive on Jan. 6th, 1927.

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

aortic Regurgitation
arteriosclerosis.

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical. Lab.

(Signed) R. A. Nicholson M. D.

Jan 7, 1927 (Address) 2230 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale

DATE OF BURIAL: 1/7 1927

20 UNDERTAKER: Jack Levin

ADDRESS: 1439 E Baltimore St

TION is very important. See instructions on back of certificates.

# HEALTH DEPARTMENT--CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 17625 (PLACE OF DEATH) 3½ REGISTERED No. E 17625

CITY OF BALTIMORE (No. 936 N. Bradford St. 7-12 St.; WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME (Mrs) Grace Huber

(Residence in Baltimore: No. 936 N Bradford St. St.; yrs. mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): married

6 DATE OF BIRTH: December 28, 1893 (Month) (Day) (Year)

7 AGE: 33 yrs. 6 mos. 7 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Charles White

11 BIRTHPLACE OF FATHER (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary Peters

13 BIRTHPLACE OF MOTHER (State or country): Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William Huber

(Address) 936 Bradford St

15. JAN 7 - 1927 HAMPSON JONES, M. D. REGISTRAR

Per R K

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: January 4, 1927 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from September, 191 , to January 4 1927, that I saw h alive on January 3, 1926, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) unknown yrs. mos. ds

Contributory (SECONDARY) Tubercular Enteritis

(Duration) yrs. mos. 21 ds.

(Signed) Frank J. Ayd M. D.

January 5, 1927 (Address) 2005 E Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: St Paul Cemetery DATE OF BURIAL: Dec 7, 1926

20 UNDERTAKER: Thos E Miller & Son ADDRESS: 2338 E Fayette St

*State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 17626

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129 E 17626

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 215 Mosher St —

CITY OF BALTIMORE: (No. 14-20 ST. WARD)

2-FULL NAME Miss Caroline Murdock

(a) RESIDENCE NO. 215 Mosher ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (write the word): Single

5a If ~~married~~, ~~widowed~~, or ~~divorced~~ HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) January 1st 1841

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| 86 | | 0 | 5 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Alexander Murdock

11 BIRTHPLACE OF FATHER (city or town) (State or country): Scotland

12 MAIDEN NAME OF MOTHER: Susan Turnbull

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Philadelphia

14 Informant: Miss Murdock (Address) 215 E Mosher St

15 Filed JAN 7 1927 C. HAMPSON JONES, M. D. Registrar per RLC

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6th 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 15th 1926 to Jan 6th 1927, that I last saw her alive on Jan 5th 1927, and that death occurred, on the date stated above, at 11.45 Am m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) many yrs. mos ds.

CONTRIBUTORY (Secondary) Senility and debility —

(duration) — yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical course

(Signed) J. W. Timmis M. D.

(Address) 1300 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Greenmount Cem | Jan 8 1927 |

20 UNDERTAKER: Henry W Jenkins Sons Co

ADDRESS: Edmondson Ave & McCulloh St

TION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17627

## CERTIFICATE OF DEATH.

161-001

E 17627

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 357 Yale Ave. St.; Ward 20-70

2-FULL NAME Baby Knodt.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 357 Yale Ave St.; yrs.. mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED.~~ Single (Write the word.)

6-DATE OF BIRTH, 1 (Month) 5 (Day), 1927 (Year)

7-AGE, ....yrs....mos. 1 da.

If LESS than 1 day, ....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....000.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Wm Lewis Knodt

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Klasmeier

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William L. Knodt

(Address) 357 Yale Ave

15-

Filed 6-1927 C. HAMPSON JONES, M. D. Registrar.

Per AKB

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 1 (Month) 6 (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 5 1927, to Jan 6 1927, that I saw h[illegible] alive on Jan 6 1927, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Prematurity

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

.....(Duration).....yrs.....mos.....ds.

(Signed) Just W Kahn M. D.

Jan 6, 1927 (Address) 3005 W North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL ~~Interred at Druid Ridge~~ London Park Baltimore DATE OF BURIAL Jan 7, 1927

20-UNDERTAKER Mr & Mrs John W Templeton ADDRESS 801 N Fayette

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## E 17628 CERTIFICATE OF DEATH. 161-001 ✓ E 17628

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1301 E. Dallas St., 8 Ward)

2-FULL NAME Baby Trogden

(a) RESIDENCE NO. 1301 E Dallas St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Black

5 Single, Married, Widowed, or Divorced. (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 8, 1926

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or 15 min. |
|---|---|---|---|---|
| | | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) U. S.

PARENTS

10 NAME OF FATHER Enoch Trogden

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) U. S.

12 MAIDEN NAME OF MOTHER Gertrude Poole

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) U. S.

14 Informant J. K. Hoerner M.D.

(Address) Johns Hopking Hospital.

15 Filed _____ 19__ C. HAMPSON JONES, M. D. Registrar

For _____

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 8 19 26

17 I HEREBY CERTIFY, That I attended deceased from Nov. 8, 1926, to Nov. 8, 1926, that I last saw her alive on Nov. 8, 1926, and that death occurred, on the date stated above, at 10 00 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) _____

(duration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted _____

If not at place of death? _____

Did an operation precede death? No Date of _____

Was there an autopsy? Yes

What test confirmed diagnosis? _____

(Signed) J. K. Hoerner, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

JOHNS HOPKINS HOSPITAL

20 UNDERTAKER — ADDRESS

JOHNS HOPKINS HOSPITAL

very important. See instructions on back of certificates.

Spec.—12 9 25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

**E 17629** CERTIFICATE OF DEATH. 161-001

E 17629

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 1501 N. Dallas St., 8-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Frogden

(a) RESIDENCE NO. 1501 N Dallas St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Black

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct. 8 1926

| 7 AGE | Years | Months | Days | IF LESS than 1 day ...hrs. or ...min. |
|---|---|---|---|---|
| | | | | 30 |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

PARENTS

10 NAME OF FATHER: Joseph Frogden

11 BIRTHPLACE OF FATHER (city or town)

(State or country): U. S.

12 MAIDEN NAME OF MOTHER: Gertrude Poole

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): U. S.

14 Informant: J. R. Hoerner M.D.

(Address): Johns Hopkins Hospital

15 Filed NOV 7 - 1927 19 G. HUMPSON JONES, M. D. Registrar

Per

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Nov. 8 19 26

17 I HEREBY CERTIFY, That I attended deceased from Nov. 8 19 26 to Nov. 8 19 26

that I last saw h.r alive on Nov. 8 19 26,

and that death occurred, on the date stated above, at 11 00 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J. R. Hoerner, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, State (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL Date of Burial 19

20 UNDERTAKER: ADDRESS: JOHNS HOPKINS HOSPITAL

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17630

CERTIFICATE OF DEATH. 161-001

E 17630

1-PLACE OF DEATH Johns Hopkins Hospital.

City of BALTIMORE: (No. _____ St. 11-7 Ward)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Clark

(a) RESIDENCE NO. 1904 E Eutaw St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Black

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec. 11, 1926

7 AGE — Years | Months | Days | IF LESS than 1 day ....hrs. or 5 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Herbert Clark

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va.

12 MAIDEN NAME OF MOTHER Vernelle Tabstead

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va.

14 Informant

(Address) Johns Hopkins Hospital.

Filed JAN 7 - 1927

C. HAMPSON JONES, M. D. Registrar

Per _____

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 11 1926

17 I HEREBY CERTIFY, That I attended deceased from Dec. 11, 1926, to Dec. 11, 1926, that I last saw him alive on Dec. 11, 1926, and that death occurred, on the date stated above, at 3:15 A.m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) J. Whitridge Williams, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

JOHNS HOPKINS HOSPITAL, 19

20 UNDERTAKER — ADDRESS

JOHNS HOPKINS HOSPITAL

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 17631

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

101-001 ✓

E 17631

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1524 Rosedale St. 16-68 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas H. Kirwan

(a) RESIDENCE NO. 1524 Rosedale St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 4 1903

7 AGE: Years 23 | Months 8 | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Merchant

(b) General nature of industry, business, or establishment in which employed (or employer): Seafood Business

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Deals Island Md.

PARENTS

10 NAME OF FATHER: Maurice L. Kirwan

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Deals Island Md.

12 MAIDEN NAME OF MOTHER: Mary E. Horton

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Deals Island

14 Informant: Maurice L. Kirwan

(Address): 1524 Rosedale St.

Filed 7 - 1927 C. HAMPSON JONES, M. D. Registrar

By: K.S.C.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 5 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 17, 1926, to Jan 5th, 1927, that I last saw h alive on Jan 5, 1927, and that death occurred, on the date stated above, at 1.30 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Septic Infection of leg (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) E. C. Hearn, M. D.

1/6 1927 (Address) 1971 Garrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Deals Island Md. Date of Burial Jan 8 1927

20 UNDERTAKER: Jos. F. Kerr ADDRESS 156 N. Luzerne

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17632

## CERTIFICATE OF DEATH

101-001 E 17632

25-72

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St. Catherine Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roy (Davis) Covell

(Waverlie Manor)

(a) RESIDENCE NO. Route 5 Balt Co. Md St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. / ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Divorced

6 DATE OF BIRTH (month, day, and year) Aug 26 1889

| 7 AGE | Years | Months | Days | IF LESS than 1 day ... hrs. or ... min.. |
|---|---|---|---|---|
| | 37 | 4 | 10 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General natore of indostry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER Phillip Covell

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Frederick Md.

12 MAIDEN NAME OF MOTHER Elizabeth Esworth

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Frederick Md

14 Informant Son Roy Jr.

(Address) Waverlie Manor

Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per R.C.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 5 1927 to Jan 6 1927

that I last saw him alive on Jan 6 1927

and that death occurred, on the date stated above, at 8 40 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (Empyema)

(duration) yrs. mos. 25 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

1-6-1926 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery Date of Burial 1-8-27

19a UNDERTAKER Bernard V. Fiske ADDRESS 734 Poplar Grove

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

Loftow

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17633

## CERTIFICATE OF DEATH.

90 E 17633

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1404 N. Eldersly ST. 5-9 WARD)

2-FULL NAME Holland Loftow

(a) RESIDENCE NO. 1404 N. Eldersly ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | C | Widowed |

5a If married, widowed, or divorced (or) WIFE of William Loftow

6 DATE OF BIRTH (month, day, and year) ? 1877

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| 50 | | ? | ? | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) ? South Carolina

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Rena Sproul (daughter)
(Address) 1404 N. Eldersly

15 Filed JAN 7 - 1927 C. HAMPSON JONES, M. D. Registrar
By K.M.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 5 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec. 15, 1926, to Jan 5, 1927, that I last saw he alive on Jan 5, 1927, and that death occurred, on the date stated above, at 7:15 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy - myocarditis

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Phys. Exam. &c.

(Signed) W. D. Berry, M. D.

, 19 (Address) 1520 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery

DATE OF BURIAL Jan 7 1927

20 UNDERTAKER Edward Bryan

ADDRESS 1631 Orleans St

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17634

## CERTIFICATE OF DEATH.

100-00

E 17634

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 233 N. Bruce St., 19-27 Ward)

2-FULL NAME Baby Ferguson

(a) RESIDENCE NO. 233 N. Bruce Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Cold

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 4/ 27

7 AGE Years Months Days IF LESS than 1 day ..... hrs. or ..... min. 34 hours

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country)

PARENTS

10 NAME OF FATHER Wm Ferguson

11 BIRTHPLACE OF FATHER (city or town) Balto,

(State or country)

12 MAIDEN NAME OF MOTHER Louise Lefpert

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Louise Ferguson

(Address) 233 n. Bruce st

Filed JAN 7 1927 HAMPSON JONES, M. D. Registrar

Per

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6 ( 1927

17 I HEREBY CERTIFY that I took charge of the remains described above, held an (Inquest, Autopsy or Inquiry) thereon and from the evidence obtained by me (or the Autopsy) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos B. Norton M. D.

(Coroner)

Jan 6, 1926 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See Reverse Side for Additional Items.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet Date of Burial Jan 7 1927

20 UNDERTAKER Joseph A Sisk ADDRESS 1501 Mount

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17635

## CERTIFICATE OF DEATH.

E 17635

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 249 Hoffman ST. 11-24 (WARD)

2-FULL NAME Sadie C D Lacy

(a) RESIDENCE NO. 249 W Hoffman ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: W. H. Lacy

6 DATE OF BIRTH (month, day, and year)

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| Abt | 52 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Lancaster Co Va

PARENTS

10 NAME OF FATHER: Wm Tiggle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Lucy Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: W. H. Lacy

(Address): 249 Hoffman

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/4 1927

17 I HEREBY CERTIFY, That I attended deceased from 1/3, 1927, to 1/4, 1927, that I last saw (s)he alive on 1/3, 1927, and that death occurred, on the date stated above, at 7.45 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Cerebral Atheroma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Gustav Hohlmann, M. D.

, 1927 (Address) 456 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: White Stone Lancaster Co Va

DATE OF BURIAL: 1/7 1927

20 UNDERTAKER: Samuel P Kennedy

ADDRESS: 518 W Biddle

Spec.—6-9-19—H. P. Co.—1000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17636

## CERTIFICATE OF DEATH.

27-55 31

E 17636

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: No. 5505 Reisterstown Rd. St. WARD.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Madeline Agness Schmid

(a) RESIDENCE. No. 5505 Reisterstown Rd. St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. 4 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry J. Schmid Jr.

6 DATE OF BIRTH (month, day, and year): Aug 27 1902

7 AGE — Years: 24 Months: 4 Days: 9 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Wm. J. Enginieer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Agnes Barnes.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Henry J. Schmid Jr. 5505 Reisterstown

Filed JAN 7 1927 19 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 6 1927.

17 I HEREBY CERTIFY, That I attended deceased from December 9. 1926. to January 6. 1927.

that I last saw her alive on January 6. 1927.

and that death occurred, on the date stated above, at 8.55 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary): Acute Brights Disease

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John D. Bubert, M. D.

19 (Address) 4854 Park Heights Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters Cem — DATE OF BURIAL: 1/8 1927

20 UNDERTAKER: D. J. Fenwick — ADDRESS: 130 E. St.

IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 17637

99-02 E 17637

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 701 N. Montford Ave ST., 7-12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Moritz Benesch

(a) RESIDENCE NO. 701 N Montford Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kathryn Benesch

6 DATE OF BIRTH (month, day, and year) Sept 7 1862

| 7 AGE Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|
| 64 | 3 | 29 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Furniture Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Chas Benesch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Chas Benesch

(Address) 701 N. Montford Ave

Filed JAN 7 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec. 20, 1926, to Jan 6, 1927.

that I last saw h alive on Jan 5, 1927.

and that death occurred, on the date stated above, at 3 35 A. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation Heart.

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis (Duration) 8 yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L D Meyer Jr, M. D.

1/6, 1927 (Address) 1520 E. 33rd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cemetery

DATE OF BURIAL Jan 9/1927

20 UNDERTAKER J. Ahearn & Co.

ADDRESS 33 W. Preston St

ATION IS very important. See instructions on back of certificate.

Spec. 12-9-25 — A Co.—200 Blks.

Dr. Webster.

Belair Rd & Belvidere

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17638

1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

90

27-41

E 17638

REGISTERED NO.

City of BALTIMORE: (No. 504 Belair Rd St. 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John B. Wagner

(a) RESIDENCE NO. 504 Belair Road St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Barbara K. Wagner

6 DATE OF BIRTH (month, day, and year): Feb 3 — 1860

7 AGE: Years 66. Months 11 Days 1 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housekeeper 08

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Germany

(State or country)

PARENTS

10 NAME OF FATHER Henry Wagner

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Barbara K. Wagner

(Address) 504 Belair Rd

Filed JAN 7 - 1927 19

C. HAMPSON JONES, M. D.

Registrar

For

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 19 27

17 I HEREBY CERTIFY, That I attended deceased from Dec 2, 1926, to Jan 4, 1927, that I last saw him alive on Jan 3, 1927, and that death occurred, on the date stated above, at 12 a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis.

Chronic Nephritis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Albert G. Webster M. D.

19 (Address) 703 Belair Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Date of Burial Jan 7 1927

20 UNDERTAKER: Wm Cook ADDRESS 502 E North Ave

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17639 E 17639

## CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4909 Edmondson Ave. WARD) 28-21

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas J. Jeanneret

(a) RESIDENCE NO. 4909 Edmondson AVE. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ida Rose Jeanneret

6 DATE OF BIRTH (month, day, and year): Oct 20 1874

7 AGE: Years 52 Months 2 Days 16 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Banker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Louis T. Jeanneret

11 BIRTHPLACE OF FATHER (city or town) (State or country): Switzerland

12 MAIDEN NAME OF MOTHER: Maria Higgins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant (Address): Ida Rose Jeanneret 4909 Edmondson Ave

Filed JAN 7 - 1927 19 HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jany 6. 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1925, to Jany 6 1927.

that I last saw him alive on Jany 1, 1927,

and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) — yrs. 2 mos — ds.

CONTRIBUTORY (Secondary) Chronic Arthritis

(duration) 1½ yrs. mos. ds.

18 Where was disease contracted if not at place of death? Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Marshall B Wood M. D.

Jan 7-27 19 (Address) Catonsville Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem

DATE OF BURIAL: Jany 8 19 27

20 UNDERTAKER: John Crutchell

ADDRESS: 1500 Eutaw Place

TION IS VERY IMPORTANT. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Eks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17640

## CERTIFICATE OF DEATH.

100-001

REGISTERED NO. E 17640

1-PLACE OF DEATH

City of BALTIMORE: (No. 26 Belleview Ave St. 27-53 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Edward Smith

(a) RESIDENCE NO. 26 Belleview Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male — 4 Color or Race: White — 5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 3 - 1926

| 7 AGE Years | Months | Days | If LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|
| — | 11 | 3 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto.

PARENTS

10 NAME OF FATHER Ambrose L. Smith

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto.

12 MAIDEN NAME OF MOTHER Lillian G. Spicer

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) West. Va

14 Informant Ambrose L. Smith

(Address) 26 Belleview ave

15 Filed JAN 7 - 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6" 19 27

17 I HEREBY CERTIFY, That I attended deceased from Jan 5 , 1927, to Jan 6 , 1927, that I last saw him alive on Jan 6 , 1927, and that death occurred, on the date stated above, at 1.30 m.

The CAUSE OF DEATH* was as follows:

Broncho. Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Icterus

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings

(Signed) Edward F. Smith, M. D.

1/6, 1927 (Address) 920 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery Date of Burial 1 8 1927

20 UNDERTAKER Thos. O. Kraus & Son ADDRESS 1118 N. Royal Ave

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17641 ✓ 159-003 E 17641

## CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St., 7-9 Ward)

2-FULL NAME Ruth Killman

(a) RESIDENCE NO. Kingsville Md. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | white | single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) Nov. 6 1926

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | | 2 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Samuel Killman

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER Margaret

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Hopkins Hospital

(Address)

Jan 1927 C. HAMPSON JONES, M. D. Registrar

Per _____

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 Jan 6/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Secondary Lobular Pneumonia

2 (Autopsy at Hopkins)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Congental Dilated Colon

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Whitridge Williams M. D.

(Coroner)

1/7/27 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Johns Cem Kingsville Md Date of Burial Jan 10 1927

20 UNDERTAKER C. E. Arthur ADDRESS Forks Md.

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17642

## CERTIFICATE OF DEATH.

× 183 E 17642

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St., 7-9 Ward)

2-FULL NAME Virginia Watkins

(a) RESIDENCE NO. Lutherville, Md. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | col | single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) Aug 14/1914

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 12 | 4 | 22 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of indnstry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Jud Washington Watkins

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Maria Watkins

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Maria Watkins

(Address) Lutherville Md

1927 C. HAMPSON JONES, M. D.

Per _____ Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5/27 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Peritonitis-Pistol Shot wound of abdomen. Accidently shot herself while handling pistol Dec 31/26

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

(duration) .....yrs. .....mos. .....ds.

(Signed) J. H. Pattee, M. D.

(Coroner)

1/6/27 19 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Owens Station Md Date of Burial Jan 7 1927 19

20 UNDERTAKER Daniel Easters ADDRESS 911

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 17643 **HEALTH DEPARTMENT—CITY OF BALTIMORE** E 17643

## CERTIFICATE OF DEATH.

129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 611 W^d Hoffman ST. 17-24 WARD)

2-FULL NAME Mary Elizabeth Means

(a) RESIDENCE NO. 611 W Hoffman ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | C | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of no

6 DATE OF BIRTH (month, day, and year) unknown

| 7 AGE Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|
| 50 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Labor

(c) Name of employer at home

9 BIRTHPLACE (city or town) (State or country) St Marys county Md

PARENTS

10 NAME OF FATHER Jackson Means

11 BIRTHPLACE OF FATHER (city or town) (State or country) St Marys Co Md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St Marys Co Md

14 Informant Catherine Blair
(Address) 433 Clifford St Balto Md

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1926, to Jan 5, 1927, that I last saw her alive on Jan 5, 1927, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Bright's

(duration) 0 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) 0 yrs. 10 mos. 11 ds.

18 Where was disease contracted if not at place of death? at 611 W^d Hoffman

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical tests

(Signed) R B Kenyon, M. D.

Jan 6. 1927 (Address) 607 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| New Cathedral | Jan 11 '27 |
| 20 UNDERTAKER Daniel Easton | ADDRESS 916 Baltimore |

THIS IS very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17644

E 17644

## CERTIFICATE OF DEATH.

16-23-25-09

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1025 W. Mount ST. 16 WARD

2-FULL NAME Rose Williams

(a) RESIDENCE NO. 1025 W. Mount ST. ..... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Col | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Henry Williams

6 DATE OF BIRTH (month, day, and year) Aug 9, 1881

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 45 | 4 | 26 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Prince George Co Md

PARENTS

10 NAME OF FATHER William Stevens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Prince George Co Md

12 MAIDEN NAME OF MOTHER Jemima Hepburn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Prince George Co

14 Informant (Address) Charles Henry Williams 1025 W. Mount St

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

7-1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 2, 1926, to Jan 5, 1927, that I last saw h[illegible] alive on Jan 4, 1927, and that death occurred, on the date stated above, at 10.20 P. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia 2 mos ds.

(duration) yrs.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1151 Streeter

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) W. H. Wright M. D.

Jan 6, 1927 (Address) 1204 Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dr Bolus Sem DATE OF BURIAL Jan 7 1927

20 UNDERTAKER Howard Easter ADDRESS 616 Gay

TION is very important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17645

## CERTIFICATE OF DEATH

100-001 E 17645

1-PLACE OF DEATH

City of BALTIMORE: (No. 1955 Edmondson ave St., 20-27 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lamanda Miller

(a) RESIDENCE NO. 1955 Edmondson St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Daniel Miller

6 DATE OF BIRTH (month, day, and year): Nov. 27-1838

7 AGE: Years 88 Months 1 Days 10 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): Self

(c) Name of employer

9 BIRTHPLACE (city or town): York

(State or country) Pa

PARENTS

10 NAME OF FATHER Elias Folkemer

11 BIRTHPLACE OF FATHER (City or town) York

(State or country) Pa

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Pa

14 Informant: Daniel Miller

(Address) 1955 Edmondson ave

15 Filed 1-7-1927 C. HAMPSON JONES, M. D. Registrar

Per DRH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6 19 27

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 19 27, to Jan 6, 19 27

that I last saw h-r alive on Jan 5, 19 27

and that death occurred, on the date stated above, at 4.30 A. m.

The CAUSE OF DEATH* was as follows:

Broncho - pneumonia

(duration) yrs. mos. 3 da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Same place

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D. H. Jones M. D.

1/7, 19 27 (Address) 920 N North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Date of Burial 1/8/27

20 UNDERTAKER: Geo. Weber & Son ADDRESS 2503 Edmondson

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17646

CERTIFICATE OF DEATH

90 E 17646

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 123 S. Bethel St. 3-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophie Voelker

(a) RESIDENCE NO. 123 S. Bethel St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Voelker

6 DATE OF BIRTH (month, day, and year) Sept 9. 1879

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 47 | 3 | 26 29 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER August Hahn

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Florentine Dryets

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant John Voelker

(Address) 123 S. Bethel St.

15 Filed 7-1927 C. HAMPSON JONES, M. D. Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec. 26, 1926, to Jan 6, 1927, that I last saw her alive on Jan 4, 1927, and that death occurred, on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Valvular Lesions of the Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Influenza

(duration) yrs. 1 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John W. Walker M. D.

, 19 (Address) 118 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Oak Lawn Cemetery | Jan 8 1927 |
| 20 UNDERTAKER Henry Sander & Sons Inc | ADDRESS 1710 Fleet St. |

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17647

66 E 17647

## CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 515 So. Addison alley Ward) 14-2

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lee Allen

(a) RESIDENCE NO. 515 So. Addison alley Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| About 38 yrs. | — | — | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town)

(State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Southwestern Police Station

(Address) Station Baltimore Md

15 1927 C. HAMPSON JONES M. D.

0934 Registrar ARH

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) December 21st 1926

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) Thos. B. Horton M. D.

(Coroner)

Jan 6th 1927 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury; and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 17648

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17648

## CERTIFICATE OF DEATH.

1-13 154-000

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1221 N. Broadway) (WARD)

2-FULL NAME Vincent Sortino

(a) RESIDENCE NO. 1221 N. Broadway ST. ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years: — Months: — Days: 2 1/3 — If LESS than 1 day, ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Charles Sortino

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Jennie Pistrato

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Charles Sortino (Address) .....

15 Jan 3, 1927 Registrar: RFW

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1-2 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 31, 1926, to Jan 2, 1927, that I last saw h[illegible] alive on Jan 2, 1927 and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Patent Foramen Ovale

(duration) ..... yrs. ..... mos 2 1/3 ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Murray L. Rittenhouse M. D.

Jan 3, 1927 (Address) 1038 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ..... DATE OF BURIAL ..... 19

20 UNDERTAKER ..... ADDRESS .....

- 1927

0000

Spec.—1-12-23—M&T—500 Bks.

Died

E 17649

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 17649

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 4003 Eastern Ave ST. 16 WARD 37

REGISTERED NO. 161-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Leone

(a) RESIDENCE NO. 4003 Eastern Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

| 7 AGE Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|
| Was Premature | | 3 | |

8 OCCUPATION OF DECEASED: None

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Salvatore Leone

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Concetta Nicoli

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant (Address): Salvatore Leone 4003 Eastern Ave

15 Filed 1927 By C. HARPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/7 1927

17 I HEREBY CERTIFY, That I attended deceased from 1/5, 1927, to 1/7, 1927

that I last saw him alive on 1/6, 1927

and that death occurred, on the date stated above, at 8 A M

The CAUSE OF DEATH* was as follows:

Premature Birth

Atelectasis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Placenta Previa

(Duration) yrs. mos. days

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. L. Lusby, M. D.

1/7, 1927 (Address) 3323 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner Health

JAN 1927

Spec.–7-17-26—A Co.—200 Bks.

E 17650

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

113 E 17650

1-PLACE OF DEATH

REGISTERED NO. 1829

City of BALTIMORE: (No. University Hospital St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Mariner

(a) RESIDENCE NO. 865½ Hollins St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 2 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Dec. 4, 1926

7 AGE: Years 1 Months Days 2 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md

(State or country)

PARENTS

10 NAME OF FATHER Harold E. Mariner

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Marie E. Carter

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va.

14 Informant Parents

(Address) 865 Hollins St.

15 Filed 1927 19 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6 19 27

17 I HEREBY CERTIFY, That I attended deceased from Jan 5, 19 27, to Jan 6, 19 27,

that I last saw her alive on Jan 6, 19 27

and that death occurred, on the date stated above, at 11:35 A.M.

The CAUSE OF DEATH* was as follows:

Acute Pneumonia Both Lungs

Otitis Media

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Elizabeth B. Harrison, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cemetery

Date of Burial: Jan 8th 1927

20 UNDERTAKER: Peter J. Gowan & Son Per P J Gowan

ADDRESS: 908 Hollins St

Very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

17651

# HEALTH DEPARTMENT—CITY OF BALTIMORE

17651 E

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mt Hope Retreat ST. 28-63 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen C O'Bryon

(a) RESIDENCE NO. Mt Hope Retreat ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) Aug 8 - 1861

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or ... min. |
|---|---|---|---|---|
| | 65 | 4 | 27 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William O Bryon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tipperary Ireland

12 MAIDEN NAME OF MOTHER Catherine Burke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Mt Hope Nurses

(Address) Mt Hope Retreat

15 Filed ... 19 ... C. HAMPSON JONES, M. D. Registrar

Per ...

- 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1924, to Jan 5, 1927, that I last saw h[illegible] alive on Jan 4, 1927, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage (Hemiplegia)

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Chronic Mania.

(duration) 22 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Place of death.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical.

(Signed) Milton P. Ford, M. D.

, 19 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem. DATE OF BURIAL. Jan. 8th 1927

20 UNDERTAKER Lilly and Zeiler ADDRESS 403 S Wolfe St.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

17652

## CERTIFICATE OF DEATH.

99-001 E 17652

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 231 S. Wolfe ST., 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Burkowski

(a) RESIDENCE NO. 231 S. Wolfe ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Husband of Julia Burkowski

6 DATE OF BIRTH (month, day, and year) Dec. 31-1860

| 7 AGE | Years | Months | Days | If LESS than 1 day... hrs. or min. |
|---|---|---|---|---|
| 66 - 860 | 66 | 0 | 5 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mechanic 31

(b) General nature of industry, business, or establishment in which employed (or employer) Stove grinder

(c) Name of employer W. A. Fertelis, Pres.

9 BIRTHPLACE (city or town) (State or country) Grodnigo Poland

PARENTS

10 NAME OF FATHER Tomasz Burkowski

11 BIRTHPLACE OF FATHER (city or town) Grodnigo (State or country) Poland

12 MAIDEN NAME OF MOTHER Agnes

13 BIRTHPLACE OF MOTHER (city or town) Grodnigo (State or country) Poland

14 Informant Julia Burkowski (Address) 231 S. Wolfe st

15 Filed 1-10-1927 C. HAMPSON JONES, M. D. Registrar Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-5-1927

17 I HEREBY CERTIFY, That I attended deceased from December 15, 1926 to January 5, 1927.

that I last saw h alive on January 5, 1927

and that death occurred, on the date stated above, at 12 15 p. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Hig h Blood Pressure

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? at the place of work

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? comp

(Signed) E. Donnal Ki M. D.

1-6-1927 (Address) 2042 Eutaw ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem. DATE OF BURIAL Jan. 8th 1927

20 UNDERTAKER Lilly and Zeiler ADDRESS 403 S. Wolfe st

TION IS very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

E 17653

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17653

## CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1808 Harlem ave ST. 16-22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME M. Caroline Meeks

(a) RESIDENCE NO. 1808 Harlem ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 15, 1875

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 51 | 9 | 21 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Business manager.

(b) General nature of industry, business, or establishment in which employed (or employer) Packers. W. W. Boyle Co.

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore Co. (State or country) Md.

PARENTS

10 NAME OF FATHER Wm A. Meeks

11 BIRTHPLACE OF FATHER (city or town) Balto Co. (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary A. Earl

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co. (State or country) Md.

14 Informant Benj. N. Meeks. (Address) 329 Woodlawn Rd.

15 Jan 8 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany. 5, 1927

17 I HEREBY CERTIFY, That I attended deceased from ~~Jany.~~ 24, 1926, to Jany. 5, 1927.

I last saw her alive on Jany 5, 1927.

I that death occurred, on the date stated above, at 6:50 p. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) — yrs. — mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Do not know.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical findings

(Signed) Maurice E. Shamer M. D.

1/7, 1927 (Address) 3300 W. North ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Loraine Cemetery | Jan 8 1927 |
| 20 UNDERTAKER George J. Smith | ADDRESS 632 Hollins |

Spec.-7-17-26—A Co.—200 Bks.

E 17654

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17654

## CERTIFICATE OF DEATH

24-04

1-PLACE OF DEATH

REGISTERED NO. 13-59

City of BALTIMORE: (No. 3017 Pennsylvania Ave St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susie Howe Kirkley

(a) RESIDENCE NO. 3017 Pennsylvania Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: W. H. Kirkley.

6 DATE OF BIRTH (month, day, and year): Oct. 14 1872

7 AGE: Years 54 Months 2 Days 23

IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER: Samuel J. Howe

11 BIRTHPLACE OF FATHER (City or town)

(State or country): York Pa.

12 MAIDEN NAME OF MOTHER: Ellen Boardman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Farmington Conn.

14 Informant: Donald Kirkley

(Address): 3011 Penna. Ave

C. HARRISON JONES, M. D.

15 Filed 1927 Per 19 Clerk Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 6 1927

Jan. 6, 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1927, to Jan 6, 1927,

that I last saw her alive on Jan 5, 1927,

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) ? yrs. mos. 5 da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Physical examination

(Signed) Harry L McCleary, M. D.

Jan 9 1927 (Address) 87 W Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — Date of Burial: Jan 8 1927

20 UNDERTAKER: George J South — ADDRESS 1532 Hollins

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 17655

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17655

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Franklin Sq. Hospital ST. 18 WARD 29 REGISTERED NO. 24-001

CITY OF BALTIMORE (No. ) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Schunk

(a) RESIDENCE NO. 939 Hollins ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| M | W | Divorced |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) Unknown 1861

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| 66 | 65 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fishing Tackle maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Wm Schunk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Lucy Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mr. Slocum

(Address) 939 Hollins St

15 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-7 1927.

17 I HEREBY CERTIFY, That I attended deceased from Jan. 7 1927. to Jan. 7 1927

that I last saw him alive on Jan. 7 1927.

and that death occurred, on the date stated above, at 3 30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Embolism

Hemiplegia (Left).

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. H. Jones M. D.

1/7, 1927 (Address) Franklin Sq Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Western | Jan 10 1927 |
| 20 UNDERTAKER Joseph B Cook | ADDRESS 1003 W Balto St |

TION IS very important. See instructions on back

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17656

## CERTIFICATE OF DEATH.

129 E 17656

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH General German Aged Home 27
City of BALTIMORE: (No.) N.E. Cor Baltimore & Payson St. 76 Ward

2-FULL NAME Louise Thanendt

(a) RESIDENCE NO. N.E. Cor Baltimore Payson St. Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. mos. ds. How long in U. S., if of foreign birth? 82 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) April 19. 1843

| 7 AGE Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|
| 83 | 8 | 19 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Hanover
(State or country) Germany

PARENTS

10 NAME OF FATHER Wilhelm Claus
11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Records of German Aged Home
(Address) N.E. Cor Balto & Payson Sts

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar
Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 7, 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1927 to Jan 7, 1927, that I last saw h.. alive on Jan 5th, 19..., and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:
Chronic nephritis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Cystitis & Cholemia

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) John A Hauff, M. D.
Jan. 7. 1927 (Address) 1843 N Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cem — Date of Burial Jan. 10 1927

20 UNDERTAKER Joseph D Cook — ADDRESS 1003 N. Balto St

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17657

## CERTIFICATE OF DEATH.

65-001 E 17657

1-PLACE OF DEATH

City of BALTIMORE: (No. 1602 Division St. 14-20 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Eugene Brown

(a) RESIDENCE NO. 1602 Division St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6 DATE OF BIRTH (month, day, and year): Nov 7 1901

7 AGE — Years: 25 — Months: 1 — Days: 26 7 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Bell Boy

(b) General nature of industry, business, or establishment in which employed (or employer): _____

(c) Name of employer: _____

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md

PARENTS

10 NAME OF FATHER: Tutie Brown

11 BIRTHPLACE OF FATHER (city or town): Calvert County

(State or country): Md

12 MAIDEN NAME OF MOTHER: Susie Woodland

13 BIRTHPLACE OF MOTHER (city or town): St Marys Co

(State or country): Md

14 Informant: Susie Brown

(Address): 1602 Division St

15 Filed: 1927 Dec

C. HAMPSON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 5 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct Nov 15, 1926, to Jan 5, 1927, that I last saw him alive on Dec 20, 1926 and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Myelois Leukaemia

(duration) 2 yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) _____

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? Blood Exam.

(Signed) Harry M. Thomas M. D.

, 19 (Address) 1914 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters Cemetery

Date of Burial: Jan 8 1927

20 UNDERTAKER: Mrs Jas. N. Dennis per T. E. Pelton

ADDRESS: 1303 Preastman St.

very important. See instructions on back of certificate.

Spec.—6-9-13—H. P. Co.—1000 Bks.

E 17658

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17658

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2132 W. Fairmount Ave. WARD 20-100-101-69

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Norman Vincent Henn, Jr.

(a) RESIDENCE. NO. 2132 W. Fairmount Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 11 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 20-1923

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 3 | 11 | 16 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Norman V. Henn,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Maud E. Forrest

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Catonsville, Md.

14 Informant (Address) Norman V. Henn, 2132 W. Fairmount Ave.

15 Filed - 1927 C. HAMPSON JONES, M. D. Registrar

Per —

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/6 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 6, 1927, to Jan 6, 1927, that I last saw h live on Jan 6, 1927, and that death occurred, on the date stated above, at 10 30 P m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

3
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? ✓

What test confirmed diagnosis? Clinical

(Signed) Keller Hemmeter M. D.

(Address) 2000 Hollins St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| New Cathedral Cemetery | Jan. 10 1927 |

20 UNDERTAKER Elmer R. Conklin ADDRESS 924 E. Eager St.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17659 — CERTIFICATE OF DEATH. — 101-001 — E 17659

1-PLACE OF DEATH St Josephs Hospital — REGISTERED NO. 17-50

CITY OF BALTIMORE (No. Caroline & Oliver St. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Henry Pymer Laborer 25 ft,

(a) RESIDENCE NO. Calvaton Apartments ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married — |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hannah E. Pymer

6 DATE OF BIRTH (month, day, and year) May 22. 1871

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or ..... min. |
|---|---|---|---|---|
| | 55 | 7 | 15 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plasterer

(b) General nature of industry, business, or establishment in which employed (or employer) 057

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) York. Co. Pa.

PARENTS

10 NAME OF FATHER Benjamin Pymer

11 BIRTHPLACE OF FATHER (city or town) (State or country) York Co., Pa.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant John B Pymer (Address) 2201 Maryland Ave

15 Filed ..... 1927 — C. HAMPSON JONES, M. D. Registrar — Per .....

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 7 - , 1927, to Jan 7 , 1927, that I last saw him alive on ~~Jan 8~~ Jan 7 , 1927, and that death occurred, on the date stated above, at 4:18 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) ... yrs. ... mos 3 ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? none

What test confirmed diagnosis? Clinical.

(Signed) Clement R. Worrall, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Delta, York Co Pa — DATE OF BURIAL Jan 10 1927

20 UNDERTAKER W. F. Cook — ADDRESS 502 E Monument

Spec—12-23-21—E.B.R.S.—400 Bks.

E 17660

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17660

## CERTIFICATE OF DEATH.

Registered No. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. 508 N. Stricker St., 7-11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hannah Jones

(a) Residence No. 508 N. Stricker St., ..... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

### PERSONAL AND STATISTICAL PARTICULARS.

| 3-SEX. | 4-COLOR OR RACE. | 5-Single, Married, Widowed, or Divorced. (Write the word.) |
|---|---|---|
| F | C | Widow |

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of ..... Geo. W. Jones

6-DATE OF BIRTH (month, day and year) Jan 29 1847

7-AGE. 79 yrs. 11 mos. 7 ds. If LESS than 1 day, hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ..... At Home

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) ..... (State or Country) Md

PARENTS.

10-NAME OF FATHER, ..... McCoy

11-BIRTHPLACE OF FATHER (city or town) ..... (State or Country) Va.

12-MAIDEN NAME OF MOTHER, ..... Margaret Graham

13-BIRTHPLACE OF MOTHER (city or town) ..... (State or Country) Md.

14- (Informant) Harriet Jones

(Address) Carrington Md

15- Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar.

Per .....

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 6 1927

17- I HEREBY CERTIFY, That I attended deceased from July 1 1926 to Jan 6 27

that I last saw h.. alive on Jan 5 27

and that death occurred, on the date stated above, at ..... m. The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Mitral Regurgitation

Acute Cardiac Dilatation

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Finding

(Signed) ..... M. D.

(Address) 100 North Pa

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Union Fun

DATE OF BURIAL. Jan 8 1927

20-UNDERTAKER. J. M. Cox

ADDRESS 502 E. Lan

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17661

## CERTIFICATE OF DEATH.

90 E 17661

1-PLACE OF DEATH

City of BALTIMORE: (No. _____ St., 7-13 Ward)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Connie Biggins

(a) RESIDENCE NO. 1054 N. Gay St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wilhom Biggins

6 DATE OF BIRTH (month, day, and year): 1852

7 AGE: Years 74 | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): ?

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Thomas Miller

11 BIRTHPLACE OF FATHER (city or town): ?

(State or country): Pa

12 MAIDEN NAME OF MOTHER: Matilda Porter

13 BIRTHPLACE OF MOTHER (city or town): _____

(State or country): Pa.

14 Informant _____

(Address) Records

15 Filed _____ 19 _____ HAMPSON JONES, M. D. Registrar

1-3-1927 Per ROA

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 5 1927

17 I HEREBY CERTIFY, That I attended deceased from August 20, 1925, to January 5, 1927, that I last saw h.. alive on January 4, 1927, and that death occurred, on the date stated above, at 9.45 P m.

The CAUSE OF DEATH* was as follows:

Senility

Chronic Myocarditis & Insufficiency

Arterial Sclerosis

(duration) ? yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) _____ yrs. _____ mos. ? ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis? general & Laboratory

(Signed) A. Hooper Smith, M. D.

Jan 6 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — Date of Burial: Jan 9 1927

20 UNDERTAKER: W. M. Cook — ADDRESS: 502 E. Oath Ave

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17662

## CERTIFICATE OF DEATH.

E 17662

179

24-34

1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore General Hospital Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph R. Stubbins, Jr.

(a) RESIDENCE NO. 1809 Covington St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. 2 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male. | White. | Single. |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) November 8, 1928.

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 8 | 2 | 8 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Joseph R. Stubbins Sr.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Anna L. Jacobs.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore, Md.

14 Informant Anna L. Stubbins. (mother)

(Address) 1809 Covington St.

15 Filed 1927 16 C. HAMPSON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 6, 1927. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burned about the face and body.
Playing with matches.
Occidental Death.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto Fernandez M. D.
(Coroner)

1/7 · 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death? 1809 Covington St. January 6 1927.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Date of Burial Jan 8 1927

20 UNDERTAKER Wm. Cook ADDRESS 502 E. Madison

very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17663 91-007 E 17663

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. 12-51

City of BALTIMORE: (No. 2710 N Charles St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harold R. Dickey

(a) RESIDENCE NO. 2710 N. Charles St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah Elizabeth Dickey

6 DATE OF BIRTH (month, day, and year): Aug 4, 1848

7 AGE: Years 78 Months 5 Days 2 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Bookkeeper

(b) General nature of industry, business, or establishment in which employed (or employer): Fidelity & Deposit

(c) Name of employer: Retired

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Geo. S. Dickey

11 BIRTHPLACE OF FATHER (City or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Caroline Rudenstein

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Miss Elizabeth N. Dickey

(Address) 2710 N. Charles St.

15 Filed Jan 18 1927 19

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 1 1926 to Jan 6 1927

that I last saw h.im alive on Jan 6 1927

and that death occurred, on the date stated above, at 12 noon.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

1927 (Address) 1206 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem. Date of Burial: Jan 8 1927

20 UNDERTAKER: Wm. J. Latane Sons. ADDRESS: Norfolk Va.

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17664

## CERTIFICATE OF DEATH.

1617-001

E 17664

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 13-3 Ward)

2-FULL NAME Baby Bourgee

(a) RESIDENCE NO. 1527 N. 29th St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word):

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct. 22, 1926

7 AGE: Years | Months | Days | IF LESS than 1 day 1 hrs. or 20 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Lloyd Bourgee

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Gladys Haggett

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant J. K. Boerner M.D.

(Address) Johns Hopkins Hospital

15 Filed _____, 19____ C. HAMPSON JONES, M. D. Registrar

Per _____

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 22 19 26

17 I HEREBY CERTIFY, That I attended deceased from Oct. 22, 1926, to Oct. 22, 1926, that I last saw him alive on Oct 22, 1926, and that death occurred, on the date stated above, at 7 45 A m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary)

(duration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J. K. Boerner, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL Date of Burial 19

20 UNDERTAKER ADDRESS

very important. See instructions on back of certificates.

8 1927

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17665

# CERTIFICATE OF DEATH.

18-26 178 E 17665

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore General Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Percy Jones.(C)

(a) RESIDENCE NO. 909 W. Mulberry St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred -- yrs. 9 mos. -- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: ~~Male~~.

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced, HUSBAND of XXXXXXXXXXXXXX Mamie Jones.(C)

6 DATE OF BIRTH (month, day, and year): Do not know.

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 25 | --------- | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (City or town)

(State or country) South Carolina.

PARENTS

10 NAME OF FATHER James E. Jones.(C)

11 BIRTHPLACE OF FATHER (city or town)

(State or country) South Carolina.

12 MAIDEN NAME OF MOTHER Julia Vaughn.(C)

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) South Carolina.

14 Informant James E. Jones.(C) father

(Address) 422 E. 4th St. Sanford Fla.

15 Filed 1927 Registrar

very important. See instructions on back of certificate.

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 5, 1927.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Burned about the face and body by an explosion aboard s/s Richelieu. Accidental Death.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signature) Otto M. Leinhardt M. D.

(Coroner)

1/7 1926 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? S. A. R. R. Co. pier Curtis Bay Jany. 4, 1927

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sumerton S. C. Date of Burial 1/8 1927

20 UNDERTAKER Samuel G. Wheeler & Bro. ADDRESS Biddeford Me.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17666

## CERTIFICATE OF DEATH.

74 E 17666

1-PLACE OF DEATH

City of BALTIMORE: (No. 1420 St. Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Euginia Barber

(a) RESIDENCE NO. 1358 N. Fremont St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Negro | Married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1889

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 40 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 37

(b) General nature of industry, business, or establishment in which, employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Georgia

PARENTS

10 NAME OF FATHER George Myers

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Georgia

12 MAIDEN NAME OF MOTHER Harriet Myers

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Georgia

14 Informant Records

(Address)

1927 C. HAMPSON JONES, M. D.

Per Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 5 1927

17

I HEREBY CERTIFY, That I attended deceased from January 4, 1927, to January 5, 1927, that I last saw h.. alive on January 5, 1927, and that death occurred, on the date stated above, at 6 15 P m.

The CAUSE OF DEATH* was as follows:

Obesity

Hypertension

Residual right Hemiplegia (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage? (duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? general & Laboratory

(Signed) R. Boogs Smith, M. D.

Jan 7. 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem Date of Burial 1/8 1927

UNDERTAKER Lawrence H. Kennedy ADDRESS 58 W. Belle

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17667

## CERTIFICATE OF DEATH.

E 17667

REGISTERED NO. 3

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1012 N. Carey ST. 16-23 WARD)

2-FULL NAME Hassey Hermand Johnson.

(a) RESIDENCE No. 1012 N. Carey ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. 4 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | Col | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 27-97

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 29 | 4 | 10 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Oyster

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Nicholas Johnson

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Sadie Bagwell

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Fletcher Drummond
(Address) 1012 N. Carey St

15 Filed 8-1927 By C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 6 - 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec. 30, 1926, to Jan. 6 - 1927, that I last saw him alive on Jan. 6 - 1927, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage of Lungs
(duration) yrs. mos 1 ds.
Tuberculosis

CONTRIBUTORY (Secondary) Tuberculosis
(duration) yrs. 5 mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Positive

(Signed) Geo W Kennard M. D.

1-6-1927 (Address) 708 Union St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem. DATE OF BURIAL Jan 8 1927

20 UNDERTAKER Wm H. Chase & Son ADDRESS 1400 Madison

Spec—12-23-21—E.B.R.S.—400 Bks.

E 17668 HEALTH DEPARTMENT—CITY OF BALTIMORE E 17668

## CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No.) 1427 (Street) Druid Hill Ave (Ward) 20

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Johnson

(a) Residence No. 1427 (Street) Druid Hill Ave St., (Ward)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Col

5-~~Single~~, ~~Married~~, Widowed, Divorced, or ~~Divorced~~, (Write the word.): Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): 1851

7-AGE: 75 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Domestic.

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Ellicott City Md

PARENTS.

10-NAME OF FATHER: Charles Anderson

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Md

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country):

14-(Informant): Dora Ruffin

(Address) 1427 Druid Hill Ave

15-Filed 1927 Per C. HAMPSON JONES, M. D. Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Jan. 5, 1927

17-I HEREBY CERTIFY, That I attended deceased from Dec 2 1926 to Jan 5 1927

that I last saw h— alive on Jan 5 1927

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

Indefinite.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? Physical Ex.

(Signed) R. Garland Thumlert M. D.

Jan 7, 1927 (Address) 1534 E. H Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: Jan 8 1927

20-UNDERTAKER: Wm. H. Chase Son — ADDRESS 1400 Mosher

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 17669

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17669

## CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1129 Woodley St. 16-22 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John C. Fallon

(a) RESIDENCE. No. 1129 Woodley ST., ..... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. 5 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena K. Fallon

6 DATE OF BIRTH (month, day, and year) July 22, 1847

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or ..... min. |
|---|---|---|---|---|
| | 79 | 5 | 15 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Lena K. Fallon (Address) 1129 Woodley St.

15 Filed JAN 8 - 1927 C. HAMPSON JONES, M. D. Registrar Per .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7, 1927

17

I HEREBY CERTIFY, That I attended deceased from April 20, 1926, to Jan. 6, 1927, that I last saw h[illegible] alive on Jan. 6, 1927, and that death occurred, on the date stated above, at 8 30 A m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acne

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Examination

(Signed) John D. Quinn, M. D.

1/7, 1927 (Address) 1507 W. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| New Cathedral Cemetery | Jan 10 1927 |
| 20 UNDERTAKER | ADDRESS |
| Jos Joerdens Son | 217 2 Pac |

THIS IS very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17670 E 17670

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hosp ST. 3rd WARD) 45

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Mathew Waitakaitis Or Wutekites

(a) RESIDENCE NO. 308 S. Bond St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. — mos. — ds. How long in U. S., if of foreign birth? 37 yrs. — mos. — ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Victoria Waitakaitis

6 DATE OF BIRTH (month, day, and year) ? 1862

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| 65 | 64 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) 080

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER no?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER no

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant Mrs. Victoria Waitakaitis

(Address) 308 S. Bond

15 Filed 8-1927 C. HAMPSON JONES, M. D. Registrar Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-7 1927

17 I HEREBY CERTIFY, That I attended deceased from 12-18-26, 19 , to 1-7 , 19 27.

that I last saw him alive on 1-7 , 19 27,

and that death occurred, on the date stated above, at 6 10 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Sigmoid

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Cutest incl Obstruction and to cancer (duration) yrs. mos. 23 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical — x-Ray

(Signed) C. C. Zimmermann, M. D.

, 19 (Address) Md. Gen'l Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Holy Redeemer | Jan 10 1927 |
| 20 UNDERTAKER | ADDRESS |
| J. Greblinskas | 423 S. Paca St. |

IT IS very important that the questions on this side be answered fully and correctly.

E 17671

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

101-001 ✓ E 17671

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. W. Balto. Genl. Hosp. St. 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Jerabek

(Residence in Baltimore: No. 16 N. Fraderia St.; yrs. 5 mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

| 3-SEX. | 4-COLOR OR RACE. | 5-Single, Married, Widowed, or Divorced. (Write the word.) |
|---|---|---|
| Male | White | Single |

6-DATE OF BIRTH. Jan (Month) 7th (Day) 1907 (Year)

7-AGE. 20 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer): W. Md. Dairy

9-BIRTHPLACE. (State or Country). City

PARENTS.

10-NAME OF FATHER. Frank Jerabek

11-BIRTHPLACE OF FATHER. (State or Country). City

12-MAIDEN NAME OF MOTHER. Josephine Planicka

13-BIRTHPLACE OF MOTHER. (State or Country). Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. Balto Genl Hospital

(Address).....

15- Filed 1927 C. HAMPSON JONES, M. D. Registrar.

8 - 1927 Par AR 12

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. 1 (Month) 7th (Day) 1927 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Emphysema

(Duration) yrs. mos. 1/2 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(Duration) yrs. mos. 1 ds.

(Signed) D. C. Hammond M. D. (Coroner)

Jan 7, 1927 (Address) 2 E Madison

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

| 19-PLACE OF BURIAL OR REMOVAL. | DATE OF BURIAL. |
|---|---|
| Oak Hill Cem. | Jan 11 1927 |

20-UNDERTAKER. Philip Herwig ADDRESS 2016 Orleans st.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17672

E 17672

## CERTIFICATE OF DEATH.

REGISTERED NO. 14

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No.) St. 23-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia Krehbiel

(a) RESIDENCE NO. 1445 Light St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widowed |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) November 4 1859

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 67 | 2 | 1 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (City or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Wilhelm Beckhaus

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Albertine Heide

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Records

(Address)

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 5 1927

17

I HEREBY CERTIFY, That I attended deceased from December 10, 1926, to January 5, 1927, that I last saw her alive on January 5, 1927, and that death occurred, on the date stated above, at 10 30 A.m.

The CAUSE OF DEATH* was as follows:

Cerebral Sclerosis

Hypertension

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? No

What test confirmed diagnosis? general observation

(Signed) R. Hobbes Lunt, M. D.

Jan 8 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bachmans Cemetery Date of Burial 1/8 1927

20 UNDERTAKER John F Berry ADDRESS 715 Light St

very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17673

## CERTIFICATE OF DEATH.

101-901

E 17673

1-PLACE OF DEATH

REGISTERED NO._____

City of BALTIMORE: (No. 222 Cusquith St. 58 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grant Catellan

(a) RESIDENCE NO. 222 Cusquith St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: C

5 Single, Married, Widowed, or Divorced. (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: [illegible]R

6 DATE OF BIRTH (month, day, and year): 1882

7 AGE: 45 Years 45 | Months — | Days — | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Lot

(c) Name of employer

9 BIRTHPLACE (city or town) .....

(State or country) Va

PARENTS

10 NAME OF FATHER unk

11 BIRTHPLACE OF FATHER (city or town) unk

(State or country)

12 MAIDEN NAME OF MOTHER unk

13 BIRTHPLACE OF MOTHER (city or town) unk

(State or country)

14 Informant Edward Bryan

(Address) 1681 Orleans St.

15 1927 Per C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1927, to Jan 4, 1927,

that I last saw h[illegible] alive on Jan 4, 1927,

and that death occurred, on the date stated above, at 4 [illegible] m.

The CAUSE OF DEATH* was as follows:

Bilateral Lobar Pneumonia

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) ..... yrs. 6 mos. ..... ds.

18 Where was disease contracted

If not at place of death? no

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Grant Catellan, M. D.

Jan 7, 1927 (Address) 508 Sommerset St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury cemetery — Date of Burial: Jan 8 1927

20 UNDERTAKER: Edward Bryan — ADDRESS: 1631 Orleans st

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 17674

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

101-001 E 17674

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

I-PLACE OF DEATH

City of BALTIMORE: (No._____ St., 7-9 Ward)

2-FULL NAME Agnes Towson

(a) RESIDENCE NO. 527 Dallas St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Negro | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1889

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 37 38 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 10 07

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Caleb Malachi

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant

(Address) Records

15 Filed ..... 19 ..... C. HARPSON JONES, Registrar

Dec

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 7 1927

17 I HEREBY CERTIFY, That I attended deceased from January 6, 1927, to January 7, 1927, that I last saw h[illegible] alive on January 7, 1927, and that death occurred, on the date stated above, at 8 30 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Gencral & Laboratory

(Signed) C. S. Harpson Jones, M. D.

Jan 8 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Coleridge M. D. Jan 8 1927

20 UNDERTAKER ADDRESS

Edward Bryan 1631 Orleans st

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17675

38 E 17675

## CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 413 Burgundy St. 22-36 Ward)

2-FULL NAME Robert Hall

(a) RESIDENCE NO. 413 Burgundy St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Born 1926

7 AGE — Years — Months: 1 — Days: 17 — IF LESS than 1 day .... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country)

PARENTS

10 NAME OF FATHER Albert Hall

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Eva Mills

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant

(Address)

8 1927 C. HAMPSON JONES, M. D. Registrar

Please MRS

0937

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/ 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an .... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said .... (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

a. Congenital Heart

Congenital Heart

b. Bronchial Pneumonia

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary)

(duration) ___ yrs. ___ mos. ___ ds.

(Signed) Harold Hanley M. D.

(Coroner)

, 19 , (Address) 413 Burg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ___ yrs., ___ mos., ___ ds. In the State ___ yrs., ___ mos., ___ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

JOHNS HOPKINS HOSPITAL

20 UNDERTAKER — ADDRESS

Commissioner of Health

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

17676 E 17676

17676

## CERTIFICATE OF DEATH

1-PLACE OF DEATH Maryland Gen. Hospital

CITY OF BALTIMORE: (No. 8-17 ST.) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Hartman

(a) RESIDENCE NO. 1202 N. Charles (ST.) Formerly Keyser St. (WARD)

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. da. How long in U. S., if of foreign birth? Life yrs. mos. da.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | white | Single. |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None.

6 DATE OF BIRTH (month, day, and year) June 2 1925.

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 1 | 10 | 4 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pre-school age.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER E. A. Hartman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Pearl Bowers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Hospital Records

(Address)

15 Filed 8 - 1927 C. HAMPSON JONES, M. D. Registrar

Per A.R.M.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1927

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1927, to June 6, 1927, that I last saw h[illegible] alive on June 5, 1927, and that death occurred, on the date stated above, at 6:55 A. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia.

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Acute Enteritis 7 days

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) John Townsend M. D.

, 19 (Address) 1 W. Mulberry St.

*State the Disease Causing Death, or if death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Harford Rd

DATE OF BURIAL 1/5 1927

20 UNDERTAKER George J. Ruth

ADDRESS 1735 Harford Ave

TION IS very important. See instructions on back

Spec.—1-12-23—M&T—500 Bks.

E 17677 HEALTH DEPARTMENT—CITY OF BALTIMORE E 17677

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH St. Josephs Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 6-10 ST. WARD)

2-FULL NAME John Maubaret.

(a) RESIDENCE NO. 1147 N. Montford ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Singe |

5a If married, widowed, or divorced (a) WIFE of HUSBAND of Annie J. Market

6 DATE OF BIRTH (month, day, and year) Jan 3 1867

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or ..... min. |
|---|---|---|---|---|
| | 60 | 0 | 2 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work, Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Markert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Rummel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Annie J. Markert (Address) 1147 N Montford Ave

15 Filed - 1927 C. HAMPSON JONES, M. D. Registrar Per

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec. 21, 1926 to Jan. 5, 1927 that I last saw h[im] live on Jan. 5, 1927 and that death occurred, on the date stated above, at 7.00 P. m.

The CAUSE OF DEATH* was as follows:

Right sided Empyema

diabetes mellitus (duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) myocarditis (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 12-22-26

Was there an autopsy? No operation

What test confirmed diagnosis?

(Signed) A. L. McNally, M. D.

19 (Address) St. Josephs Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL 1/10 1927

20 UNDERTAKER George J. Ruth 1730 Halford Ave

ADDRESS

Spec—12-23-21—E.B.R.S.—400 Bks.

E 17678

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

38 E 17678

Registered No.

1-PLACE OF DEATH University Hospital

City of BALTIMORE: (No. Lombard & Green St. 16-7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Cornish

(a) Residence No. 807 N. Mount St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Baby

6-DATE OF BIRTH (month, day and year) 12-30-26

7-AGE. ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, 6 hrs. or 45 min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Baby Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Mary Land

PARENTS.

10-NAME OF FATHER, Phillip Zayos

11-BIRTHPLACE OF FATHER (city or town) (State or Country), New York

12-MAIDEN NAME OF MOTHER, Amelia Comish

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Mary Land

14- (Informant)

(Address)

15- Filed JAN 3 1927 C. HAMPSON JONES, M. D. Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 12-31-26

17- I HEREBY CERTIFY, That I attended deceased from 12-30 1926 to 12-31 1926

that I last saw h[illegible] alive on 12-31 1926

and that death occurred, on the date stated above, at 1 30 P.M.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Maternal Sepsis

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eva T. Dodge M. D.

, 19 (Address) University Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

| 19-PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL, ..... 19 .... |
|---|---|
| 20-UNDERTAKER, | ADDRESS |

JOHNS HOPKINS HOSPITAL

JAN 3 - 1927

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17679

## CERTIFICATE OF DEATH.

E 17679

100-001

10-14

1-PLACE OF DEATH

City of BALTIMORE: (No. Jouns Hopkins Hospital St., Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Howell

(a) RESIDENCE NO. 800 Harford Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | col | single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of XXXXXX

6 DATE OF BIRTH (month, day, and year) May 1/24

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 2 | 7 | 3 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Franklin N. C.

PARENTS

10 NAME OF FATHER Frank Howell

11 BIRTHPLACE OF FATHER (city or town)
(State or country) N.C.

12 MAIDEN NAME OF MOTHER AnnieHarris

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) N. C.

14 Informant Frank Howell
(Address)

Filed 1- 1927 Per C. HAMPSON JONES, M. D. Registrar

very important. See instructions on back of certificate.

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Bronchopneumonia (Primary)
(duration) yrs. mos. 14 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) J. E. Weller M. D.
(Coroner)
1/6/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Henderson NC Date of Burial 1/8/ 1927

20 UNDERTAKER Byron Wright & McElroy ADDRESS 1218

Spec.—12-9-25—A Co.—200 Blks.

E 17680

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129 E 17680

REGISTERED NO.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. 23-31 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Hawkins

(a) RESIDENCE NO. 814 Leadenhall St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Female | Negro | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1887

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 40 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Dave Hawkins

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Anna Hawkins

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Records

(Address)

15 1927 C. HAMPSON JONES, M. D. Registrar

Copy

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 5 1927

17

I HEREBY CERTIFY, That I attended deceased from October 22, 1926, to January 5, 1927, that I last saw h.. alive on January 5, 1927, and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Chronic Myocarditis & Insufficiency

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) yrs. mos. 7 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? general & laboratory

(Signed) R. Hooper Smith, M. D.

Jan. 6 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Mt Zion Cemy 1/8 1927

20 UNDERTAKER Mrs Jos A Hooper ADDRESS 406 N Conway St

VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 17681

118-001 E 17681

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 26-37 Ward)

2-FULL NAME Wm. Niedling

(a) RESIDENCE NO. 3708 Ogmwood St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 2 1926

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | | 2 | 4 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country)

PARENTS

10 NAME OF FATHER Wm. Niedling

11 BIRTHPLACE OF FATHER (city or town)

(State or country) B. Co.

12 MAIDEN NAME OF MOTHER Barb. Blauth

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto

14 Informant Barb. Niedling

(Address) 3708 Ogmwood

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6. 27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

due to hernia

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) ..... M. D.

(Coroner)

Jan 7. 1927 (Address) 1639 Bruns

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cem. Date of Burial Jan. 8th 1927

20 UNDERTAKER: Lilly and Zirkin ADDRESS: 403 S. Wolfe St.

very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 17682

## CERTIFICATE OF DEATH.

E 17682

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 904 Asquith St. 10-14 Ward)

2-FULL NAME Anna R. Fink

(a) RESIDENCE NO. 904 Asquith St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank M. Fink

6 DATE OF BIRTH (month, day, and year) June 26/1904

| 7 AGE Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|
| 22 | 6 | 10 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) 37

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER Venceslaus Butta

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Austria

12 MAIDEN NAME OF MOTHER Mary Butta

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Austria

14 Informant Frank M. Fink

(Address) 904 Asquith St

15 Filed Jan 10 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1. 1927, to Jan 6, 1927, that I last saw h.. alive on Jan 6, 1927, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Ryan M. D.

Jan 7, 1927 Address 2012 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem Date of Burial Jan 10 1927

20 UNDERTAKER Frank A. Fink ADDRESS 915 N. Gay

very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

19622 E 17683

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1002 Ped 10 E 17683

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No.) 15-21 (Street) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Hay

(a) RESIDENCE NO. 1607 N. Mount ST., Alley WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Colored | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown.

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or min. |
|---|---|---|---|---|
| 9½ | | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James Hay

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Lorraine Symmonds

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed NOV 9 1927 By C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 22, 1926, to Jan 7, 1927, that I last saw her alive on Jan 7, 1927 and that death occurred, on the date stated above, at 9:50 a.m.

The CAUSE OF DEATH* was as follows:

Ulcerative Stomatitis (Vincents) (Agranulocytosis)

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Microscopic Exam

(Signed) Thomas O. Cromwell M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Broad Neck Cem

DATE OF BURIAL 1.10 1927

UNDERTAKER E H B Parker

ADDRESS 92 W Pratt Cem Holes

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17684

## CERTIFICATE OF DEATH.

188-001

E 17684

1-PLACE OF DEATH Claremont yard B&O RR Blue top Bridge Washington Boulevard

REGISTERED NO.

City of BALTIMORE: (No. S. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Benjamin Hoerr

(a) RESIDENCE NO. 1811 N. Caroline St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Dec 16 1902

7 AGE: Years 24 — Months — Days 23 — IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Brakeman B&O RR.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer —

9 BIRTHPLACE (city or town): St. Paul, Minn.

(State or country)

PARENTS

10 NAME OF FATHER F.C.C. Hoerr

11 BIRTHPLACE OF FATHER (city or town): Balto

(State or country)

12 MAIDEN NAME OF MOTHER Stella Burns

13 BIRTHPLACE OF MOTHER (city or town): Camden, N.J.

(State or country)

14 Informant: John A. Hoerr

(Address) 1811 N. Caroline St

15 Filed ....., 19 ..... Per C. HAMPSON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 8 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull Dead When Found

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) found on B&O Tracks

(duration) ....yrs. ....mos. ....ds.

(Signed) Thos. B. Horton M. D.

(Coroner)

Jan 8, 1927 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cem — Date of Burial: 1-10-1927

20 UNDERTAKER: Robert Brooks & Son — ADDRESS: Baltimore Hollins sts

very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 17685

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 E 17685

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. _____

City of BALTIMORE: (No. 518 S. Paca 22-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Earl Tyson

(a) RESIDENCE NO. 518 S. Paca St. Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 1. 1926

| 7 AGE | Years | Months | Days | IF LESS than 1 day, ____ hrs. or ____ min.. |
|---|---|---|---|---|
| | | 4 5 | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. bbl

(b) General natore of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Clarence Tyson

11 BIRTHPLACE OF FATHER (City or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Wilhelmina Baker

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Clarence Tyson
(Address) 518 S Paca St.

15 Filed _____, 19 _____ C. HARRISON JONES, M. D. Registrar
Per _____

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19
Jan. 7 - 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 5, 19 27, to Jan. 7, 19 27, that I last saw h[e] alive on Jan. 7, 19 27, and that death occurred, on the date stated above, at 9:10 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia
(Primary)

(duration) _____ yrs. _____ mos. 3 ds.

CONTRIBUTORY —
(Secondary)

(doration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted

If not at place of death? _____

Did an operation precede death? _____ Data of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Thurlby Craig, M. D.

Jan 8 19 27 (Address) 7 Granby & Bloc

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Hanover

Date of Burial Jan 10 19 27

20 UNDERTAKER Ehenowith & Son.

ADDRESS 3617 Chestnut Ave

Jan 8 - 1927

very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17686

E 17686

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 15-58

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2623 Kate Av. St.) (WARD)

2-FULL NAME Olive Elizabeth Frock.

(a) RESIDENCE. NO. 2623 Kate Av. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Samuel S. Frock.

6 DATE OF BIRTH (month, day, and year) Nov. 16, 1851

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 75 | 1 | 21 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER George W. Wengel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine F. Kibler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Lily Winters
(Address) 1 Carroll Road.

15 Filed JAN 9 - 1927 C. HAMPSON JONES, M. D. Registrar
By R K

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 6, 1927.

17 I HEREBY CERTIFY, That I attended deceased from January 2, 1924 to January 6, 1927.
that I last saw h[illegible] alive on January 6, 1927.
and that death occurred, on the date stated above, at 8:03 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) John S. Quinn, M. D.

1/7 1927 (Address) 1507 N. Fulton Avenue.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Jan 10 1927

20 UNDERTAKER: Chenowith & Son — ADDRESS: 3617 Chestnut Av

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17687

## CERTIFICATE OF DEATH

57 E 17687

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. 13-52 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Maude M Wilhelm

(a) RESIDENCE NO. 3500 Roland Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced (or) WIFE of Clarence E. Wilhelm

6 DATE OF BIRTH (month, day, and year) Aug 10, 1881

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| 45 46 | 4 | 17 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Co.

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town) Unknown

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown

(State or country)

14 Informant Clarence E. Wilhelm

(Address) 3500 Roland Ave.

JAN 9 - 1927

C. HAMPSON JONES, M. D. Registrar

Per R R

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 6, 1927, to Jan 7, 1927

that I last saw her alive on Jan 7, 1927

and that death occurred, on the date stated above, at 8 30 P. m.

The CAUSE OF DEATH* was as follows:

Diabetus Mellitus with impending coma

(duration) 2 yrs. mos. da.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 da.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Chem 1/4

(Signed) Ekmeller, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Hampden

Date of Burial Jan 11, 1927

UNDERTAKER Edmonds Horton

ADDRESS 3615 Elmora Ave

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

Daisy E. Lippy

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17688

## CERTIFICATE OF DEATH.

90 E 17688

1-PLACE OF DEATH Homewood Hosp

CITY OF BALTIMORE (No. 2724 Charles St. 27-56 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daisy Lippy

(a) RESIDENCE No. 4213 Park Ave WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 26. 1878

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 48. | 10 | 12 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Candy Packer

(b) General nature of industry, business, or establishment in which employed (or employer) Mutty Washington Candy Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Geo. Lippy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Emma R Shelling

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mr Elmer Lippy

(Address) 4213 Park Ave Baltimore Md

15 Filed JAN 4 - 1927 C. HAMPSON JONES, M. D. Registrar

By

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 1927 to Jan 8 1927

that I last saw h[illegible] alive on Jan 8 1927

and that death occurred, on the date stated above, at 2 hrs 0 m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Acute Lobar Pneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? 4213 Park Ave

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Chas F Kelly M. D.

1/11 1927 (Address) 2784 W Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet

DATE OF BURIAL Jan 11 1927

20 UNDERTAKER Wm Cook

ADDRESS 607 E Baltimore

Spec—12-23-21—E.B.R.S.—400 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17689 E 17689

## CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

City of BALTIMORE: (No. 2516 E. Monument St., 8-16 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Ebersweir

(a) Residence No. 2516 E. Monument St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. W

5-Single, Married, Widowed, or Divorced. (Write the word.) Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Wilson Ebersweir

6-DATE OF BIRTH (month, day and year) Sept 14, 1875

7-AGE. 51 yrs. 3 mos. 22 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. At Home

(b) General nature of Industry, business, or establishment in which employed (or employer). 0

(c) Name of employer.

9-BIRTHPLACE (city or town). (State or Country). Balt Md

PARENTS

10-NAME OF FATHER. Wm Foster

11-BIRTHPLACE OF FATHER (city or town). (State or Country). Balt Md

12-MAIDEN NAME OF MOTHER. Anna Youngman

13-BIRTHPLACE OF MOTHER (city or town). (State or Country). Balt Md

14- (Informant) Theresa Ebersweir

(Address) 2516 E. Monument St.

15- Filed Jan 9, 1927 C. HARRISON JONES, M. D. Registrar. By K.C.

### MEDICAL CERTIFICATE OF HEATH.

16-DATE OF DEATH (month, day and year). Jan 6 1927

17- I HEREBY CERTIFY, That I attended deceased from July 10, 1926, to Jan. 8, 1927.

That I last saw h alive on Jan 6, 1927,

and that death occurred, on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Uterine Hemorrhage

(Duration) yrs. mos. 1 ds

CONTRIBUTORY (Secondary) Leucocytosis chronic

Hemorrhage Uterine

(Duration) yrs. 20 mos. ds

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) G. H. Mayer M. D.

1/8, 1927 (Address) 1501 E. 33rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore

DATE OF BURIAL. Jan 10, 1927

20-UNDERTAKER. W. Cook

ADDRESS 502 Edmondson

Spec.—6-9-19—H. P. Co.—1000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17690

E 17690

## CERTIFICATE OF DEATH.

REGISTERED NO 46

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8 S Calhoun St. 14-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary J Wiistland

(a) RESIDENCE. NO. 8 S Calhoun ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry H Wiistland

6 DATE OF BIRTH (month, day, and year) Nov 11, 1888

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 38 | 1 | 26 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Peter J McGuire

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Young

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Anna T Sullivan (Address) 8 S Calhoun St

15 Filed JAN 9 - 1927 Per C. HAMPTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 27, 1926, to Jan 7, 1927, that I last saw her alive on Jan 7, 1927, and that death occurred, on the date stated above, at 6:15 P. m.

The CAUSE OF DEATH* was as follows: Carcinoma of Uterus

CONTRIBUTORY (Secondary) Pulmonary Oedema (duration) yrs. 3 mos. 11 ds.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) James R Bagenstos M. D.

1/8, 1927 Address 17 29 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Jan 10 1927

20 UNDERTAKER William Cook — ADDRESS 502 E North Ave

Spec.-7-17-26—A Co.—200 Bks.

E 17691

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17691

## CERTIFICATE OF DEATH

31

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hospital St., 21-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Clarence Recken

(a) RESIDENCE NO. 724 N Cross St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M. | W. | M. |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 7, 1885

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| 41 42 | | 5 | 28 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) 087

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland

(State or country)

PARENTS

10 NAME OF FATHER Frank Loan

11 BIRTHPLACE OF FATHER (City or town) Maryland

(State or country)

12 MAIDEN NAME OF MOTHER Christina Loan

13 BIRTHPLACE OF MOTHER (city or town) Balto Md

(State or country)

14 Informant Christina Recken

(Address) 724 N Cross St

15 Filed 9 - 1927 Per C. HAMPSON JONES, M. D. Registrar RRR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-5 1927

17 I HEREBY CERTIFY, That I attended deceased from 11-11, 1926, to 1-5, 1927, that I last saw him alive on 1-5, 1927, and that death occurred, on the data stated above, at 11:30 P m.

The CAUSE OF DEATH* was as follows:

Tuberculous Pulmonalis

(duration) 8 yrs. mos. da.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. 1 mos. 14 da.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab

(Signed) J Riella M.D., M. D.

1-6, 1927 (Address) 1122 N Mount St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — Date of Burial 1-10 1927

20 UNDERTAKER Eo B Hasla — ADDRESS 115 E North Ave

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 17692

# E 17692 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 633N Bond (St.) 6-4 (Ward)

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Green

(a) RESIDENCE NO. 633 N. Bond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or WIFE of): Sarah Green

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE: Years: Approx 67; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Anne Arundel Co Md

PARENTS

10 NAME OF FATHER: Alex. Green

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Alice Ulmstead (daughter) 733 N Bluff St

15 Filed 1-8-1927 G. HAMPSON JONES, M. D., Registrar. Per C.R.R.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 6 1927

17 I HEREBY CERTIFY, That I attended deceased from 1st part of Oct., 1926, to Jan 6, 1927, that I last saw h alive on Jan 6, 1927, and that death occurred, on the date stated above, at 10:58 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary): Severe Bronchitis and Hypostatic Pneumonia

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) R. J. Young, M. D.

1/8, 1927 (Address) 1424 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mayer Thp. Anne Arundel Md — DATE OF BURIAL: 1-9-1927

20 UNDERTAKER: James H. Kleinschmidt — ADDRESS: 120 E. Madison St

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17693 — 74-001 — E 17693

1-PLACE OF DEATH — CERTIFICATE OF DEATH. — Registered No. E 17693

City of BALTIMORE: (No. 3706 Chestnut Road St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Paul Breckenridge Perdue

(Residence in Baltimore: No. 712 E Baltimore St.; 38 yrs. ..... mos. ..... ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: M

4-COLOR OR RACE: W.

5-~~Single~~, Married, Widowed, or ~~Divorced~~. (Write the word.): Widower

6-DATE OF BIRTH: Aug 5th 1851 (Month) (Day) (Year)

7-AGE: 75 yrs. 5 mos. 3 ds. If LESS than 1 day, ....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cigar Factory Proprietor
(b) General nature of industry, business, or establishment in which employed (or employer): Rooting & Alley

9-BIRTHPLACE, (State or Country): New Kent Co. Va

PARENTS.

10-NAME OF FATHER: Wm Perdue

11-BIRTHPLACE OF FATHER, (State or Country): Va

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER, (State or Country): Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Caroline Perdue

(Address) 3706 Chestnut Road

15- Filed 9 1927 Per 192 C. HAMPTON JONES, M. D. Registrar. R.C.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Jan 8th 1927 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or Inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

a Aortic - Sclerosis

(Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) [illegible] M. D. (Coroner)

Jan. 9 1927 (Address) 212 E Lanvale St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Monumental Cemetery Co Va — DATE OF BURIAL: Jan 9th 1927

20-UNDERTAKER: J Bertram Cole — ADDRESS: 1723 Lafayette Ave

Spec.–7-17-26—A Co.–200 Bks.

E 17694

# HEALTH DEPARTMENT—CITY OF BALTIMORE

49 E 17694

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. _____

City of BALTIMORE: (No. St. Agnes Hospital St. 19-28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John C. Weber

(a) RESIDENCE NO. 1507 W. Pratt St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced. (write the word): widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 8, 1856

7 AGE — Years: 71 — Months: — — Days: — — IF LESS than 1 day ____ hrs. or ____ min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): ____

(c) Name of employer: ____

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER not given

11 BIRTHPLACE OF FATHER (City or town) "

(State or country)

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) "

(State or country)

14 Informant ~~the~~ niece – Miss Pearl Hunter

(Address) 3526 Frederick Ave

Filed JAN 9 - 1927 19 C. HAMPSON JONES M. D. Registrar

Per _____

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-8 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov. 21, 1926, to Jan 8, 1927, that I last saw him alive on Jan 8, 1927, and that death occurred, on the date stated above, at 3 15 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

and myocardial insufficiency

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Carcinoma prostate ?

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted

If not at place of death? ____

Did an operation precede death? Yes Date of ____

Was there an autopsy? No

What test confirmed diagnosis? Clinical & autopsy

(Signed) [illegible], M. D.

1/8, 1927 (Address) St. Agnes' Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — Date of Burial: Jany 10 1927

20 UNDERTAKER: Harry A Armacost — ADDRESS 4204 Ridgewood Ave

very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17695

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. E 17695

City of BALTIMORE: (No. 506 N. Schroeder St. 18-26 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Apfolina Rosenberger

(a) Residence No. 506 N. Schroeder St., Ward,
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 4 mos. 9 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Antone Rosenberger

6-DATE OF BIRTH (month, day and year) Aug 28 59

7-AGE. 67 yrs. 4 mos. 9 ds. If LESS than 1 day, ....hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9-BIRTHPLACE (city or town) Balto
(State or Country),

PARENTS.

10-NAME OF FATHER, John Kirk

11-BIRTHPLACE OF FATHER (city or town) Germany
(State or Country),

12-MAIDEN NAME OF MOTHER, not known

13-BIRTHPLACE OF MOTHER (city or town) Germany
(State or Country),

14- (Informant) Theresa Rosenberger
(Address) 506 N. Schroeder St

15- Filed 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 6-27

17- I HEREBY CERTIFY, That I attended deceased from Nov 23 1926 to Jan 6 1927

that I last saw h[illegible] alive on Jan 3 1927

and that death occurred, on the date stated above, at 11.30 A.M.

The CAUSE OF DEATH* was as follows:

Mitral valve insufficiency
& nephritis

(Duration) abt yrs. 1 mos. 14 ds

CONTRIBUTORY (Secondary) Cardiac decompensation

(Duration) yrs. 1/2 hr mos. ds

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? usual tests

(Signed) H. E. Knight M. D

1927 (Address) 1023 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL. 1-10-27

20-UNDERTAKER. H. C. Brannigan Son — ADDRESS 517 N. Schroeder St

Spec. 10-21-M-2 5M Bks.

E 17696

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129 E 17696

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 403 S. Bentalou ST. 20-69 WARD)

2-FULL NAME Mollie Stainke

(a) RESIDENCE NO. 403 S. Bentalou ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... dt.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced—
HUSBAND of (or) WIFE of William J. Stainke

6 DATE OF BIRTH (month, day, and year) June 22, 1864

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 62 | 6 | 15 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Herman Henneman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Bibella Bates

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant F. W. Nuessle
(Address) 403 S. Bentalou St.

15 Filed Nov 9 1927 C. HAMPSON JONES, M. D.
Per RRK Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 25, 1926 to Jan 6, 1927.

that I last saw her alive on Jan 6, 1927

and that death occurred, on the date stated above, at 7.45 P. m.

The CAUSE OF DEATH* was as follows:

Nephritis Chronic

(duration) — yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) Uremia

(duration) — yrs. — mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Coma

(Signed) [illegible], M. D.

Dec 28, 1927 (Address) 517 London

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| London Park | Jan. 10, 1927 |

UNDERTAKER Mrs. John W. Teufel & Son

ADDRESS 801 W. Fayette

THIS IS VERY IMPORTANT. DO NOT FOLD.

Spec.—1-10-21—M&T—1500 Bks.

Ellen Bryne

E17697.

# HEALTH DEPARTMENT—CITY OF BALTIMORE E 17697

## CERTIFICATE OF DEATH.

101-001

REGISTERED NO. 17697

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1621 Lamont Av ST. 10-15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Byrne

(a) RESIDENCE NO. 1718 Eastern Av ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1855

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 71 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Store Keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Luke Byrne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Hanora Rogers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Evans

(Address) 1621 Lamont Ave

15 Filed JAN 10 1927

C. HAMPSON JONES, M. D. Registrar

Per RRR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-7 1927

17

I HEREBY CERTIFY, That I attended deceased from 1/5 . 1927 . to 1/7 . 1927 .

that I last saw h[illegible] alive on 1/7 . 1927 .

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D Berman Wolf, M. D.

1/8, 1927 (Address) 914 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

DATE OF BURIAL Jan 12 1927

20 UNDERTAKER Dela Penfield

ADDRESS 914 Greenmount Ave

TION is very important.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

151 ✓ **E 17698**

REGISTERED NO. 1698

**E 17698**

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor St. 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Easter

(a) RESIDENCE NO. Preston & Valley St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | Colored | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1850

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 77 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Joel Easter

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER Eugenia Easter

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Little Sisters of the Poor

(Address) Preston & Valley St.

Filed JAN 10 1927 C. HAMPSON JONES, M. D. Registrar

Per RRA

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 Jan 8th

17 I HEREBY CERTIFY, That I attended deceased from No record, 19..... to ....., 19....., that I last saw h.. alive on January 7, 1927, and that death occurred, on the date stated above, at 4.50 a. m.

The CAUSE OF DEATH* was as follows:

Senile gangrene of foot

(duration) .....yrs. 1 mos. 0 ds.

CONTRIBUTORY

(Secondary)

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F A Warner, M. D.

Jany 8, 1927 (Address) 133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — Date of Burial Jan. 12 1927

20 UNDERTAKER Rula Kindsvatter — ADDRESS 914 Gramont

very important. See instructions on back of certificate.

1 PLACE OF DEATH E 17699

County Balto City

Village or City Balto., (No. 208 [illegible] 6-20

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mary Hollingsworth Harry - 50 yrs

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Widow

6 DATE OF BIRTH: Dec (Month) 20 (Day) 1842 (Year)

7 AGE: 84 yrs. — mos. 12 ds. If LESS than 1 day ... hrs. or ... min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country): Harford Co. Md.

PARENTS

10 NAME OF FATHER: Nathaniel Hollingsworth

11 BIRTHPLACE OF FATHER (State or country): Harford Co. Md.

12 MAIDEN NAME OF MOTHER: Mary Warner

13 BIRTHPLACE OF MOTHER (State or country): Harford Co. Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. E. Hollingsworth

(Address) Hoppa Md.

15 Filed ... 192... WILLIAMSON JONES, M.D. Registrar

By ...

JAN 10 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: January 8th (Month) (Day) 1927 (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Oct. 7th. 1926 to Jany 8th. 1927. that I last saw her alive on Jany 7th, 1927, and that death occured on the date stated above, at 7 a. m.

The CAUSE OF DEATH * was as follows:

Gastric Carcinoma of unknown duration

(Duration) ... yr. ... mos. ... ds.

Contributory Secondary: Myocarditis

(Duration) 4 yrs. ... mos. ... ds.

(Signed) Eleanor C. Price, M. D.

1-8- 1927 (Address) 1705 Park Ave.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Friends Cemetery, Fallston Md.

DATE OF BURIAL: Jan 10th 1927

20 UNDERTAKER: Jos E. Hornberger

ADDRESS: Benson Md

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

Statement of OCCUPATION is very important

Spec.—1-12-23—M&T—500 Bks.

E 17700

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17700

## CERTIFICATE OF DEATH.

10-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST., 15-21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leon Dogolaw

(a) RESIDENCE No. 1928 N. Payson St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 3, 1926

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 1 | 6 | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER David

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rosa Ruff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant David Dogolaw

(Address) 1928 N. Payson St.

Filed 1-0-1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1927, to Jan 9, 1927, that I last saw h[illegible] alive on Jan 9, 1927, and that death occurred, on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(duration) yrs. mos 7 da.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 7 da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Intubated Date of Jan 1, 1927

Was there an autopsy? No

What test confirmed diagnosis? Path. & Dipth. Culture

(Signed) Myron G. Tull, M. D.

1-9, 1927 (Address) Sydenham Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Friendship — DATE OF BURIAL 1-11-1927

20 UNDERTAKER Post Lewis, 1434 E. Balto — ADDRESS

Spec.–7-17-26—A Co.—200 Bks.

E 17701

# HEALTH DEPARTMENT—CITY OF BALTIMORE

38-E 17701

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. University Hospital St. 16-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sylvia Holton

(a) RESIDENCE NO. 869 Harlem Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| F | Black | Widowed |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 17, 1881

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min.. |
|---|---|---|---|---|
| | 45 | 10 | 19 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housemaid

(b) General nature of industry, business, or establishment in which employed (or employer) Private

(r) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Wm. Saxon

11 BIRTHPLACE OF FATHER (City or town) Baltimore

(State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Saxon

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Md.

14 Informant Nadia Foller

(Address) 869 Harlem Lane

15 Filed ..... 19 ..... HARRISON JONES Registrar

Per RK

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1st 1926 to Jan. 6 1927

that I last saw h.. alive on Jan. 6 1927

and that death occurred, on the date stated above, at 2:50 P m.

The CAUSE OF DEATH* was as follows:

Polycystic Kidneys; Chronic Interstitial Nephritis, Uremia, General Arteriosclerosis, C.V. Renal.

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. 2 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) E. R. Miller M. D.

19 (Address) University Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem Date of Burial Jan 9 1927

20 UNDERTAKER Lamb Easton? ADDRESS 94

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 202

E 17702

REGISTERED NO. E 17702

E 17702
1-PLACE OF DEATH

City of BALTIMORE: (No. _____ St. 12-51 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William (Christian) or (Christopher)

(a) RESIDENCE NO. 1505 Bernard St. _____ Ward _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Negro | ? |

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1876 ?

| 7 AGE | Years | Months | Days | If LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 50? | | | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 40
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Virginia

PARENTS

10 NAME OF FATHER Wm Christopher

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Mary —

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant
(Address) Records

Filed JAN 10 1927, 19... C. HAMILTON JONES, M. D.
Registrar
Per RC

very important. See instructions on back of certificate.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 6 1927

17 I HEREBY CERTIFY, That I attended deceased from April 7, 1926, to January 6, 1927, that I last saw him alive on January 5, 1927, and that death occurred, on the date stated above, at 1A m.

The CAUSE OF DEATH* was as follows:
Arterial Sclerosis
Chronic Myocarditis
Chronic Infectious Arthritis
(duration) ? yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia
(duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted
If not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? general & laboratory

(Signed) C. H. Hodges Jones M. D.
Jan 7. 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pr Cemetery Date of Burial Jan 10 1927

20 UNDERTAKER Ward & Easton ADDRESS 944 Pa ave

Spec.—12 9 25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1703.

**E 17703**

**CERTIFICATE OF DEATH.**

31

**E 17703**

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Baltimore City Hospitals St. (E B L) Ward) 17-24

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laudonia Walker

(a) RESIDENCE NO. 823 W. Biddle st. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | Colored | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isaiah Walker

6 DATE OF BIRTH (month, day, and year) 1904

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 22 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework (2)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER Oscar Watkins

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed JAN 10 1927, 19 C. HAMILTON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 7, 1927

17 I HEREBY CERTIFY, That I attended deceased from October 9 19 26, to January 7, 19 27,

that I last saw her alive on January 7, 19 27,

and that death occurred, on the date stated above, at 12.15 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

Pulmonary (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) C. H. Watkins, M. D.

1-8-27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Date of Burial Jan 9 1927

20 UNDERTAKER Daniel Easton ADDRESS 916 Baltimore

very important. See instructions on BACK of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 17704

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 17704

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1422 N. Mount ST. 15-21 WARD) 100-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena M. Coates

(a) RESIDENCE NO. 1422 N. Mount ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Fem | Colored | Married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1888

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 37 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Harry Gross

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Lizzie Bladen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant albert Scott (Address) 1422 N mount st

15 Filed JAN 18 1927 19 Registrar C. HARRISON JONES, M. D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 5 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 5, 1927, to Jan. 6, 1927, that I last saw her alive on Jan 6, 1927, and that death occurred, on the date stated above, at 8.25 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) 1 yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr J W Kennard, M. D.

1-7, 1927 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn bur — DATE OF BURIAL Jan 9, 1927

20 UNDERTAKER David Easton — ADDRESS 916 Pine

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## E 17705 CERTIFICATE OF DEATH

90 E 17705

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 716 S. East Ave St. 1-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara F. Corouna.

(a) RESIDENCE NO. 716 S. East Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John A. Corouna.

6 DATE OF BIRTH (month, day, and year) Jan. 12 – 1859

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|---|
| | 68 | 11 | 24 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER Andrew Bauer.

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Margaret Roesch.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany.

14 Informant John A. Bauer (Husband)

(Address) 716 S. East Ave.

Filed JAN 10 1927, 19

C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 5th – 27

17 I HEREBY CERTIFY, That I attended deceased from April 29", 19 26, to January 5", 19 27,

that I last saw her alive on January 5", 19 27,

and that death occurred, on the date stated above, at 7.40 P. m.

The CAUSE OF DEATH* was as follows:

Mitral & Aortic Insufficiency,

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Decompensation Heart,

(duration) yrs. 1 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Caleb R. Athey, M. D.

Jan 6" 1927 (Address) 100 S Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem. Date of Burial Jan. 10th 1927.

20 UNDERTAKER Lilly & Zeiler ADDRESS 403 S Bdwy

OF DEATH in plain terms, and very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 17706

Tult

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 17706

## CERTIFICATE OF DEATH.

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 930 Penna. Ave. St. 17-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bercklay Tult

(a) RESIDENCE NO. 930 Penna Ave St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | Colored | married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Grace Tult

6 DATE OF BIRTH (month, day, and year) [illegible]

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 43 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook 3 Hugs

(b) General nature of industry, business, or establishment in which employed (or employer) Rest

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Va.

PARENTS

10 NAME OF FATHER Henry Tult

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Va.

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) [illegible]

14 Informant Grace Tult

(Address) 930 Penna Ave

15 Filed JAN 10 1927, 19____ C. HAMILTON JONES, M. D.

Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry thereon and from the evidence obtained by said inquest, autopsy or inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Lobar Pneumonia

(duration) ____ yrs. ____ mos. 4 ds.

CONTRIBUTORY (Secondary) Cardiac history

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. C. Hamilton Jones M. D.
(Coroner)

Jan 7 1927 (Address) 202 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ____ yrs., ____ mos., ____ ds. In the State ____ yrs., ____ mos., ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem Date of Burial Jan 10 1927

20 UNDERTAKER Daniel Easton ADDRESS 911 Pa Ave

Very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 17707

E 17707

## CERTIFICATE OF DEATH.

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2104 W. Mulberry St., 20-69 Ward)

2-FULL NAME Bessie M. Lederer

(a) RESIDENCE NO. 2104 W. Mulberry St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | white | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm C. Lederer

6 DATE OF BIRTH (month, day, and year) March 2nd 1882

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 44 | 10 | 5 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country)

PARENTS

10 NAME OF FATHER John P. Hines

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country)

12 MAIDEN NAME OF MOTHER Ida M. McGinnis

13 BIRTHPLACE OF MOTHER (city or town) Balto.

(State or country)

14 Informant Wm C. Lederer

(Address) 2104 W. Mulberry St

15 Filed ..... 19 ..... C. HAMILTON JONES, P. D.

NOV 1927 Per ..... Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7th 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) ..... yrs. ..... mos. At once ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. B. Norton M. D.

(Coroner)

Jan 8. 1927 (Address) Curtis Bay.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury; (2) whether Accidental, Suicidal, or Homicidal. (See instructions on back of certificate for additional items.) Balto Md.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery Date of Burial Jan 11 1927

20 UNDERTAKER F. B. Hupfer ADDRESS 1852 N. Eutaw St

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

Clintnik

# HEALTH DEPARTMENT—CITY OF BALTIMORE

88-003

E 17708

## CERTIFICATE OF DEATH.

E 17708

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St. 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank. Clintnik

(a) RESIDENCE NO. 516 S Durham St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 5-1920

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 6 | 4 | 2 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Stanislaus Clintnik

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Wolenya Kuczynska

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Stanislaus Clintnik

(Address) 516 S Durham St

Filed JAN 10 1927 Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull Auto. Accident

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock

(duration) yrs. mos. ds.

Signed Jno. J. Gilbert M. D.

(Coroner)

(Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Russia

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Date of Burial Jan 10 1927

20 UNDERTAKER John M Weber ADDRESS 1803 Bank St

very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks. (SYLVESTER IZDEPSKI) 001

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17709

## CERTIFICATE OF DEATH.

24 100 E 17709

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 240 S Washington ST., 7-24 WARD)

2-FULL NAME Sylvester Izdepski

(a) RESIDENCE NO. 240 S Washington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | S |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 6 1926

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min |
|---|---|---|---|---|
| | | 1 | 2 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Michael Izdepski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto md

12 MAIDEN NAME OF MOTHER Sophia Gialkowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto md

14 Informant Mr Michael Izdepski
(Address) 240 S Washington St

15 Filed [illegible] Registrar

NOV 10 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7 1927

17 I HEREBY CERTIFY, That I attended deceased from 11 4, 1926, to 1-7 1927,
that I last saw h[illegible] alive on 1-7-27 and that death occurred, on the date stated above, at 1015 p m.

The CAUSE OF DEATH* was as follows:

a Bronchitis

Bronchial Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) Daniel L Dinkey, M. D.

1927 (Address) 33 E Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Holy Rosary | Jan 10 1927 |

20 UNDERTAKER John M Weber ADDRESS 1805 Bank st

Cor.—1-12-23—M&T—100 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17710

## CERTIFICATE OF DEATH.

E 17710

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Union Memorial Hospital ST., (Or WARD)

REGISTERED NO. 84-003

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fannie E. Phillippy

(a) RESIDENCE NO 2907 Orleans ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

6a If married, widowed, or divorced HUSBAND) of (or) WIFE of: John Phillippy

6 DATE OF BIRTH (month, day, and year): Feb 22 1884

7 AGE: Years 42; Months 10; Days 15; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Telephone
(b) General nature of industry, business, or establishment in which employed (or employer): Operator 609
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: B. H. Tase

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Lotie E Jeffers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Mrs B. H. Tase
(Address) 665 Gutman ave

15 Filed JAN 10 1927 C. HAMPSON JONES, M. D. Registrar

Per

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 7 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Injuries from Auto Accident

Accidental

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Chas. H. Hampson, M. D. (Coroner.)

1/10 1927 (Address) 1622 Roland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oakland Cemetery — DATE OF BURIAL 1/10 1927

20 UNDERTAKER: Wm Cook — ADDRESS 502 E North

E 1771 HEALTH DEPARTMENT—CITY OF BALTIMORE E 1771

# CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. West Balto. Gen. Hosp. ST.) 1561 (WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laura Praeger

(Residence in Baltimore: No. 3410 Grantly Road St.; 16 yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

| 3-SEX. | 4-COLOR OR RACE. | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) |
|---|---|---|
| female | white | single |

6-DATE OF BIRTH. September (Month) 6 (Day), 1873 (Year)

7-AGE. 53 yrs. 8 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION.
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. Henry Praeger

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Kate

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Emilie L. Tosch

(Address) 26 Somerset Road

15- C. HAMPSON JONES, M. D.

Filed NOV 10 1927, 191 Per Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 6 (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull
Struck by automobile

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. E. Hennessy M. D.
(Coroner)

Jan 8 1927 (Address) 2602 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

| 19-PLACE OF BURIAL OR REMOVAL. | DATE OF BURIAL. |
|---|---|
| Druid Ridge Cemetery | Jan. 10, 1927 |
| 20-UNDERTAKER | ADDRESS |
| John O. Mitchell & Son | 1900 Eutaw Pl. |

Spec.—12-9-25—A Co.—200 Bks.

(Mary Bailey)

# HEALTH DEPARTMENT—CITY OF BALTIMORE

X 100-001

E 17712

E 17712

## CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Mercy Hospital

City of BALTIMORE: (No._____ St. 11-24 Ward)

2-FULL NAME Mary Bailey

(a) RESIDENCE NO. 217 N. Fremont St. Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | colored | widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of widow

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| 43 | | — | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

9 BIRTHPLACE (city or town) [redacted]

(State or country) Harford Co

PARENTS

10 NAME OF FATHER Smith

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Jno T Foster

(Address) Bel Air Md

Filed JAN 10 1927

C. HAMPSON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 3 1927 to Jan 9 1927, that I last saw h.. alive on Jan 9 1927, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C Smith, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mountain Harford Co Md Date of Burial January 11 1927

20 UNDERTAKER Deaver & Foster ADDRESS Bel Air Md.

Very Important. See Instructions on Back of Certificate

Spec.—8-14-14—M. & T.—2000 blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17713

## CERTIFICATE OF DEATH.

90 E 17713

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 211 Cedar Ave St. 13-57 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Jacob Allison

(Residence in Baltimore: No. 211 Cedar Ave St. Same yrs. mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-[SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)] Married

6-DATE OF BIRTH, Jan 2 (Month) (Day), 1860 (Year)

7-AGE, 67 yrs. mos. 6 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Pa.

PARENTS.

10-NAME OF FATHER. John J. Allison

11-BIRTHPLACE OF FATHER (State or Country). Pa

12-MAIDEN NAME OF MOTHER. Mary E. Morris

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna R. Allison

(Address) 211 Cedar Ave

15-

Filed ..... 191.....

Registrar.

C. HAMILTON JONES, M. D.

JAN 10 1927

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 1 (Month) 8 (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1925, to Jan 8 1927, that I saw him alive on Jan 8 1927, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Myocarditis and Arteriosclerosis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) yrs. 1 mos. ds.

(Signed) [illegible] M. D.

Jan 7, 1927 (Address) 8429 Stanford Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt Zion Cemetery DATE OF BURIAL, Jan 11, 1927

20-UNDERTAKER A S Marshall ADDRESS 3839 Falls Road

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

17714

101-001

E 17714

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2426 E. Preston St. 8-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Mc Cormick

(a) RESIDENCE NO 2426 E Preston St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | W | Widowed |

5a If married, widowed, or ~~divorced~~ ~~HUSBAND of~~ (or) WIFE of Patrick Mc Cormick

6 DATE OF BIRTH (month, day, and year) 1840

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min.. |
|---|---|---|---|---|
| | 86 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General natore of indostry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ireland

(State or country)

PARENTS

10 NAME OF FATHER Montbron

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Fr.

12 MAIDEN NAME OF MOTHER Montbron

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ire

14 Informant Emma Fore

(Address) 2426 E Preston St

C. HAMPSON JONES, M. D.

15 Filed JAN 10 1927 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 3 1927 to Jan 6 1927

that I last saw h~~e~~r alive on Jan 3 1927

and that death occurred, on the date stated above, at 1130 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY

(Secondary)

(doration) yrs. mos ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) C. Hampson Jones M. D.

(Address) 1305 N Calhoun St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injory, and (2) Whether Accidental, Soicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Com

Date of Burial 1/10 1927

20 UNDERTAKER J. A. Moran

ADDRESS 300 E Baltimore

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17715

## CERTIFICATE OF DEATH

× 100-001

E 17715

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Univ. Hospital St. 4-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jean Fraser

(a) RESIDENCE NO. 26 Highway Road Sundalk St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 27, 1925

7 AGE: Years 1 Months 9 Days 12 IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Hanover Pa

(State or country) Maryland

PARENTS

10 NAME OF FATHER Frank Fraser

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Scotland

12 MAIDEN NAME OF MOTHER Jeanette Stewart

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Scotland

14 Informant Frank Fraser

(Address) Sundalk Md

Filed ANG 0 192 C. HAMPSON JONES, M. D.

Per Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 8 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1927, to Jan 8, 1927

that I last saw h[illegible] alive on Jan 8, 1927.

and that death occurred, on the date stated above, at 5-00 P m.

The CAUSE OF DEATH* was as follows:

Emphysema

Influenza

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos 4 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? yes Date of 1-7-27

Was there an autopsy? no

What test confirmed diagnosis? Opinion

(Signed) R S Anderson, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — Date of Burial: Jan 10 1927

20 UNDERTAKER: H. Sander Sons Inc — ADDRESS: 1710 Pennsylvania Ave

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

Brodt

# HEALTH DEPARTMENT—CITY OF BALTIMORE

90

**E 17716**
1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

REGISTERED NO. **E 17716**

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

City of BALTIMORE: (No.) 2010 N. Fulaski St., 15-68 Ward)

2-FULL NAME Henry P. Brodt

(a) RESIDENCE NO. 2010 N. Fulaski St. Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth 74 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE of~~ Katharine Marie Brodt

6 DATE OF BIRTH (month, day, and year) August 31st 1852

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 74 | 4 | 10 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Grocer
(b) General nature of Industry, business, or establishment in which employed (or employer) Store (retail)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Germany

PARENTS

10 NAME OF FATHER Henry Brodt

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Kohlhepp

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs Katharine Marie Brodt
(Address) 2010 N Fulaski St

15 Filed ..... 19 .....
C. HAMPSON JONES, M. D.
Registrar
NOV 10 1927
By .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 9th 1927 19

17 I HEREBY CERTIFY, That I attended deceased from May 1924, to January 9 1927, that I last saw him alive on January 9 1927, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:
Cerebral Arteriosclerosis Cerebral Hemorrhage Arteriosclerosis & Senile General Decline
(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Instability to walk - Delusions or food
(duration) yrs. mos. 7 ds.

18 Where was disease contracted
If not at place of death
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Probable
(Signed) Edward L. Brodt, M. D.
1927 (Address) 1605 N Ford ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR~~ REMOVAL Cedar Hill Date of Burial Jan. 12 1927

20 UNDERTAKER Geo W Little ADDRESS 1700 Edmondson Ave

very important. See INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17717

## CERTIFICATE OF DEATH.

44 E 17717

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2100 E Balto st ST. 6-11 WARD)

2-FULL NAME Meyer Singer

(a) RESIDENCE NO. 2100 E Balto st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., If of foreign birth? 17 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Esel Singer

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 45 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Lewis 1439 E Balto st

15 Filed JAN 10 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1927, to Jan 9, 1927, that I last saw h[illegible] alive on Jan 9, 1927 and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach.

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Unknown.

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Lewis Weinstein, M. D.

, 19 (Address) 1810 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

DATE OF BURIAL 1/10 1927

20 UNDERTAKER Jack Lewis 1439 E Balto st

ADDRESS

TION IS VERY important. See instructions on back of

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17718

## CERTIFICATE OF DEATH.

E 17718

REGISTERED NO. 16001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 47 S. Schroeder ST. 18-29 WARD)

2-FULL NAME Mary Collins

(a) RESIDENCE No. 47 S. Schroeder ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. — mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Jan. 3. 1927.

7 AGE: Years — Months — Days 6. If LESS than 1 day, — hrs. or — min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Oakley Collins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Bertha Blake

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penna

14 Informant: Oakley Collins, (Address) 47 S. Schroeder St

15 Filed 1927. H. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 9. 1927.

17 I HEREBY CERTIFY, That I attended deceased from Jan. 3rd. 1927. to Jan. 9. 1927.

that I last saw her alive on Jan. 8. 1927.

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Premature Birth.

(7 mo. Gestation)

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? General Physical Exam.

(Signed) Chas. Norton, M. D.

(Address) 888 N. Longwood St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery — DATE OF BURIAL: Jan 10 1927

20 UNDERTAKER: Geo. J. Smith — ADDRESS 1532 Mullins

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17719 : CERTIFICATE OF DEATH. 129 E 17719

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital 9-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gertrude Kuhrman

(a) RESIDENCE NO. 132 Forrest Road St. Sparrow's Point Md Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | white | single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) Feb 24/1914

| 7 AGE | Years | Months | Days | IF LESS than 1 day ...hrs. or ...min. |
|---|---|---|---|---|
| | 12 | 10 | 11 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Wm Kuhrman

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Bamke

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Elizabeth Kuhrman

(Address) Parkton Md

Filed 1927 C. HUMPSON JONES, M. D. Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis-Acute Tracheaitis & Bronchitis

(Autopsy at Hopkins)

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Terminal Acidisis (duration) ... yrs. ... mos. ... ds.

(Signed) J. C. Weller M. D.

(Coroner)

1/8/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial Oakland Cemetery Jan 10 1927

20 UNDERTAKER ADDRESS Harry H Weitzel 53 W Lanvale St

very important. See instructions on back of certificate.

AN TO 1927

Spec.—1-10-21—M&T—1500 Bks.

17720

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

29 E 17720

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 517S Monroe St., ST. 14-28 WARD)

2-FULL NAME Anna Rebecca Bell,

(a) RESIDENCE NO. 517 S Monroe St., ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Frank Bell

6 DATE OF BIRTH (month, day, and year) Feb. 16. 1839

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 87 | 10 | 22 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER William Paul

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Laura M. Crofoot,

(Address) 517 S. Monroe St.

15 Filed 1-10-1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-7 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 1st 1927, to Jan 7 1927.

that I last saw her alive on Jan 6 1927.

and that death occurred, on the date stated above, at 4 am m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

CONTRIBUTORY (Secondary) Asthma (duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Physical

What test confirmed diagnosis?

(Signed) Benj W Cryer M. D.

1/8 1927 (Address) 700 N Clayton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Melvale Cemetery Elkridge Md.

DATE OF BURIAL 1/10/27

20 UNDERTAKER Harry H. Weitzel

ADDRESS 153 Windsor

Cor.—12-9-25—A Co.—200 Bks.

E 17721

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

100-001a

E 17721

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1005 McCulloh St., 11-24 Ward)

2-FULL NAME Thelma Matthews

(a) RESIDENCE NO. 1005 McCulloh St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| | Female colored | single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) September 1925

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | | | 1 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER John Matthews

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Lucy Gibson

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Annie Matthews
(Address) 1005 McCulloh St

15 Filed APR 10 1927 19 C. HAMPSON JONES, M. D.
Per K.F. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an.....(Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said.....(Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

(duration) .....yrs. .....mos. .....ds.

(Signed) .....M. D.
(Coroner)

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs., .....mos., .....ds. In the State.....yrs., .....mos., .....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Date of Burial April 10 1927

20 UNDERTAKER Virginia A. Brooks ADDRESS 1463 N Carey

very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17722

## CERTIFICATE OF DEATH.

90 E 17722

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. ____ St., 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Williams

(a) RESIDENCE NO. 1512 E Oliver St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred (?) yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1860

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 67 | | | |

8 OCCUPATION OF DECEASED: Housework

(a) Trade, profession or particular kind of work: Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Maryland

PARENTS

10 NAME OF FATHER William Williams

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Edna (?)

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Maryland

14 Informant: City Hospitals Records

(Address)

15 Filed JAN 10 1927, 19

C. HAMPSON JONES, M. D.

Per R.H. Registrar

very important. See instructions on back of certificate.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 8 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1927, to Jan 8, 1927, that I last saw h[illegible] alive on Jan 8, 1927, and that death occurred, on the date stated above, at 11:21 a.m.

The CAUSE OF DEATH* was as follows:

Myocarditis - Chronic
and acute
Hypertension

(duration) ....yrs. 6 mos. ....ds.

CONTRIBUTORY Bronchopneumonia
(Secondary)

(duration) ....yrs. ....mos. 2 ds.

18 Where was disease contracted

If not at place of death? (?)

Did an operation precede death? [illegible] Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Symptoms

(Signed) C. Hampson Jones, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltoleem. Date of Burial Jan 11th 1927

20 UNDERTAKER: Leo G. Cook ADDRESS 1723 N Patterson Ave

Spec.—12 9-25—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 17723 — REGISTERED NO.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. ____ St., 76-37 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Johnson

(a) RESIDENCE NO. Noel - Missouri St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | white | Widowed |

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1871

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 56 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Paper Hanger

(b) General nature of industry, business, or establishment in which employed (or employer) ____

(c) Name of employer ____

9 BIRTHPLACE (city or town) ____

(State or country) Ohio

PARENTS

10 NAME OF FATHER Robert Johnson

11 BIRTHPLACE OF FATHER (city or town) ____

(State or country) Va

12 MAIDEN NAME OF MOTHER Sarah

13 BIRTHPLACE OF MOTHER (city or town) ____

(State or country) Va

14 Informant ____

(Address) Records

Filed JAN 10 1927 — C. HAMPSON JONES, M. D., Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 5 1927

17 I HEREBY CERTIFY, That I attended deceased from January 3, 1927, to January 5, 1927, that I last saw him alive on January 5, 1927, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Sclerosis

Chronic Myocarditis & Pneumonia

(duration) ____ yrs. 2 mos. ____ ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ____ yrs. ____ mos. 3 ds.

18 Where was disease contracted if not at place of death? ____

Did an operation precede death? no Date of ____

Was there an autopsy? no

What test confirmed diagnosis? general & laboratory

(Signed) H. Hoopu Smith M. D.

Jan 6 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem Date of Burial Jan 10 1927

20 UNDERTAKER Leo S. Cook ADDRESS 1723 Park Ave

very important. See instructions on back of

Spec—12-23-21—E.B.R.S.—400 Bks.

E 17724

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17724

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 745 Bartlett Av St. 9-46 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Metzger

(a) Residence No. 745 Bartlett Av St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, Divorced, (write which word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept. 16, 1925

7-AGE. 1 yrs. 3 mos. 23 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Joseph H. Metzger

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Australia

12-MAIDEN NAME OF MOTHER, Eleanor Reinig

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md

14- (Informant) Eleanor Reinig Metzger

(Address) 745 Bartlett Ave

15- Filed NOV 10 1927 C. HAMPSON JONES, M. D. Per Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 8, 1927

17- I HEREBY CERTIFY, That I attended deceased from Feb 14 19 27 to Jan 8, 19 27

that I last saw h alive on Jan 8, 19 27

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Marasmus

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Premature Birth

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Wm. D. Peck M. D.

Jan 7, 19 27 (Address) 936 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19-PLACE OF BURIAL, CREMATION OR REMOVAL. | DATE OF BURIAL. |
|---|---|
| Holy Redeemer | 1/10/27 19 |

20-UNDERTAKER. Mary M. Wiedefeld Jr. ADDRESS 501 E. 22 St.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17725

## CERTIFICATE OF DEATH.

117

E 17725

1-PLACE OF DEATH So Balt Gen Hosp. REGISTERED NO. 02-30

City of BALTIMORE: (No. 1211 Light St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Carlisle

(a) RESIDENCE NO. 30 Hill St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): ~~Single~~ Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret Carlisle

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 74 | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Elevator pender

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Del.

PARENTS

10 NAME OF FATHER: Sam Carlisle

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER: Mary Ballard

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Del

14 Informant: Mrs. A. Wilson

(Address): 38 1/2 Edmondson Ave

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

Registrar

10 1927 Rec'r

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 7 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 1927 to Jan 7, 1927,

that I last saw h[illegible] alive on Jan 7, 1927,

and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Diffuse peritonitis (Cancer)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) ..... yrs. ..... mos. ..... ds.

Is Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 1/7/27.

Was there an autopsy?

What test confirmed diagnosis?

(Signed) ~~H.~~ O Miller, M. D.

, 19 (Address) South Balt Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery Date of Burial Jan 10 1927

20 UNDERTAKER: John F. Young ADDRESS 715 Light St

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17726

129

## CERTIFICATE OF DEATH.

REGISTERED No. E 17726

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1013 N. Carey St., 16-23 Ward)

2-FULL NAME Laura A. Champion

(a) RESIDENCE NO. 1013 N. Carey St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | Colored | Married |

3a If married, widowed, or divorced HUSBAND of (or) WIFE of John D Champion

6 DATE OF BIRTH (month, day, and year) Sept 7 1877

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 49 | 3 | 7 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Warren Co. NC

PARENTS

10 NAME OF FATHER Codwell Powell

11 BIRTHPLACE OF FATHER (city or town)

(State or country) NC

12 MAIDEN NAME OF MOTHER Winnie Dawlen

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) NC

14 Informant John D Champion

(Address) 1013 N. Carey St.

15 Filed 19 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7 19 27

17 I HEREBY CERTIFY, That I attended deceased from Nov 1 19 26 to Jan 7 19 27

that I last saw h.er alive on Jan 7 19 27

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

(duration) yrs. 2 mos. 20 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Microscopic

(Signed) , M. D.

, 19 (Address) 1126 Druid Hill

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery Date of Burial Jan 10 19 27

20 UNDERTAKER Chas H. Dennis per T. E. Kelson ADDRESS 1303 Pennsylvania Ave

Very Important. See instructions on back of this sheet.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 17727

E 17727

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital. St. 22-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Daniels.(C)

(a) RESIDENCE NO. 16 W. Church St. St._____ Ward Mo

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred __ yrs. 9 mos. _ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male. | Colored | Married. |

5a If married, widowed or divorced
HUSBAND of
XXX XXXXXX Annie Daniels.(C)

6 DATE OF BIRTH (month, day, and year) Do not know.

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 36 | -------- | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) St. Louis Mo.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Do not know.

14 Informant Annie Daniels(C) wife.

(Address) 16 W Church St.

C. HAMPTON JONES, M. D.

JAN 10 192 Per _____ Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 5, 1927. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Burned about the face and body by an explosion aboard the S/S Richlieu. Occidental Death.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

(duration) .....yrs. .....mos. .....ds.

(Signature) Otto M Leinhardt M. D.

1/10 1927 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? U.S.F.O.B.S.Co. pier Curtis Bay Jan. 4, 1927

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Cem. Date of Burial Jan 10 1927

UNDERTAKER S. H. Brown & Son ADDRESS 1000 W. Fayette St.

Very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17728

## CERTIFICATE OF DEATH.

100-001

E 17728

1-PLACE OF DEATH Union memorial Hospital

CITY OF BALTIMORE: (No. 33[illegible] a Calvert ST. 71-53 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. John A. Spilman

(a) RESIDENCE NO. St. George & Roland Ave. ST. City WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lucille Martin Spilman

6 DATE OF BIRTH (month, day, and year) April 15 1898

7 AGE: Years 48; Months 8; Days 25; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pres. of Md Drydock

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER William Spilman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Lucille Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Arthur D. Fulton

(Address) 605 Roland ave

JAN 10 1927 C. HAMPSON JONES, M. D. Registrar

Per [signature]

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 9 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 31, 1926, to 5:45 AM. 1/9, 1927, that I last saw him alive on Jan 9, 1927, and that death occurred, on the date stated above, at 5:45 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) W. A. Hamond, M. D.

, 19 (Address) Union Memorial Hosp. Tal.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holly Wood. Richmond Va

DATE OF BURIAL: 1/11 1927

20 UNDERTAKER: Henry W. Jenkins' Sons Co

ADDRESS: Orchard & McCulloh St.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17729

## CERTIFICATE OF DEATH.

75-001

E 17729

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 127 W Lafayette Ave ST 11-20 WARD)

2-FULL NAME Sarah Elizabeth Creton

(a) RESIDENCE NO. 127 W Lafayette Ave ST., ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced HUSBAND of (or) ~~Wife~~ of Mr Wesley Demellar Creton

6 DATE OF BIRTH (month, day, and year) Aug 13. 1848

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min |
|---|---|---|---|---|
| | 78 | 4 | 25 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Mt Jackson Va

PARENTS

10 NAME OF FATHER Andrew J Hunckhouse

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mt Jackson Va

12 MAIDEN NAME OF MOTHER Elizabeth Kinker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mt Jackson Va

14 Informant George Creton

(Address) 127 W Lafayette Ave

15 Filed JAN 10 1927 HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 16 1926, to Jan 18 1927, that I last saw h alive on Jan 7, 1927 and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Effusion

Cerebral Effusion

(duration) yrs 3 mos ds.

CONTRIBUTORY (Secondary) Hemiplegia

(duration) yrs 6 mos. ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? Date of No

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John A Cuddy, M. D.

, 19 (Address) 612 W 40 St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Druid Ridge Cem | Jan 10 1927 |

| 20 UNDERTAKER | ADDRESS |
|---|---|
| Henry J Kirkin Sons & Co | McCulloh & Eutaw Sts |

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17730

E 17730

## CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

City of BALTIMORE: (No. _____ St., 16-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Moulton

(a) RESIDENCE NO. 106 N. Schroeder St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Negro | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1887

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 39 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter Jr

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Moulton

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Betty —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant

(Address) Records

15 Filed C. HAMPSON JONES, M. D. Registrar

By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 6 1927

17 I HEREBY CERTIFY, That I attended deceased from December 8, 1926, to January 6, 1927, that I last saw h-m alive on January 6, 1927, and that death occurred, on the date stated above, at 2 45 P m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency

Chronic Myocarditis & Insufficiency

(duration): ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? general & laboratory

(Signed) R. Hooper Lamb M. D.

Jan 8 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery Date of Burial Jan. 11 1927

20 UNDERTAKER Mrs Estelle R. Williams ADDRESS 322 N. Schroeder St

Spec.—6-9-19—H. P. Co.—1000 Bks.

17731

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

3 E 17731

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1265 Rumsdale Ave (St.) 24-20 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME — Raymond G. Burns

(a) RESIDENCE. No. 1265 Rumsdale Ave St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Georgia Burns

6 DATE OF BIRTH (month, day, and year) — 1889

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 37 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Spanno Bro. Bottle Co.

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Clinton Burns

11 BIRTHPLACE OF FATHER (city or town) (State or country) Montgomery Co Md

12 MAIDEN NAME OF MOTHER Hattie Crawford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Montgomery Co

14 Informant — Georgia Burns

(Address) 1265 Rumsdale Ave

15 Date received JAN 10 1927 C. HAMPSON JONES, M.D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/7 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 30, 1926, to 1/7, 1927.

that I last saw h[e] alive on 1/7, 1927.

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C. Hampson Jones M. D.

1/10, 1927 (Address) 1299 Williams

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL |
|---|---|
| Loudon Park | 1/10 1927 |
| UNDERTAKER | ADDRESS |
| F. H. Gilmore & Son | 1515 Light St |

Spec.–7-17-26—A Co.—200 Bks.

E 17732

# HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

E 17732

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 2812 Baker St. 16-67 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Raleigh Kenneally

(a) RESIDENCE NO. 2812 Baker St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 8 mos. 24 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lillie M. Kenneally

6 DATE OF BIRTH (month, day, and year): Apr. 15, 1855

7 AGE — Years: 71 Months: 8 Days: 24 IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Foreman

(b) General nature of industry, business, or establishment in which employed (or employer): Lumber Dept

(c) Name of employer: B. & O. R.R.

9 BIRTHPLACE (city or town): Balto.

(State or country): Md.

PARENTS

10 NAME OF FATHER: George Kenneally

11 BIRTHPLACE OF FATHER (City or town): Unknown

(State or country)

12 MAIDEN NAME OF MOTHER: Emily Raleigh

13 BIRTHPLACE OF MOTHER (city or town): N.Y.

(State or country)

14 Informant: Mrs. Lillie M. Kenneally

(Address) 2812 Baker St

15 Filed ..... 19 ..... Registrar

By .....

very important. See instructions on back of certificate.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 8 19 27

17 I HEREBY CERTIFY, That I attended deceased from 12-18, 1926, to 1-8, 1927, that I last saw him alive on 1-8, 1927, and that death occurred, on the date stated above, at 10.30 P m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) yrs. 2 mos. 4 ds.

CONTRIBUTORY (Secondary): Hypostatic Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) A. C. Grant, M. D.

19 (Address) 1207 Poplar Grove

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. Date of Burial: Jan 11 1927

20 UNDERTAKER: W. H. Fickus Sons ADDRESS: Northern

ANTO 1927 THOMPSON-WOODS CO.

Spar. 7-17-26 A Co. 200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17733

## CERTIFICATE OF DEATH

100 E 17733

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 382 Forrest Park St., 15-6d Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Peterson

(a) RESIDENCE NO. 382 Forrest Park St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J. M. Peterson

6 DATE OF BIRTH (month, day, and year) July 30, 1846

| 7 AGE | Years | Months | Days | IF LESS than 1 day ... hrs. or ... min.. |
|---|---|---|---|---|
| | 80 | 5 | 10 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER Perry Bateman

11 BIRTHPLACE OF FATHER (City or town) Unknown.

(State or country)

12 MAIDEN NAME OF MOTHER Matilda Cox.

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Mrs. Matilda B. Fitter

(Address) 382 W. Forrest Park Ave

JAN 10 1927 HAMPSON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 Jan. 9 27

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1926, to Jan 9 th, 1927

that I last saw h e alive on Jan 9, 1927

and that death occurred, on the date stated above, at 6.30 a m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted Home

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Course

(Signed) M. Bayley, M. D.

. 19 (Address) 3048 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Bethel Cem. Chesapeake City Md | Jan 11 1927 |
| 20 UNDERTAKER Wm J Tickner & Sons | ADDRESS North & Pa |

very important. See instructions on back of certificates.

Spec.—12-9-25—A [illegible]o.—200 Bks.

E 17734

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 17734

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 124 W Lamdonth St. 22-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sadie Dangelo

(a) RESIDENCE NO. 124 W Lamdonth St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: white.

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Vincent Dangelo

6 DATE OF BIRTH (month, day, and year): unknown 1889

7 AGE: Years 37; Months —; Days —; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 37

(c) Name of employer

9 BIRTHPLACE (city or town): Cefalu

(State or country) Italy

PARENTS

10 NAME OF FATHER: John Machione

11 BIRTHPLACE OF FATHER (city or town): Cefalu

(State or country) Italy

12 MAIDEN NAME OF MOTHER: Garzia Correra

13 BIRTHPLACE OF MOTHER (city or town): Cefalu

(State or country) Italy

14 Informant: Mr Vincent Dangelo

(Address) 124 W Lamdonth St

Filed [illegible] 1927 [illegible] Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1-8 1927

17

I HEREBY CERTIFY, That I attended deceased from 11-8, 1926, to 1-8, 1927,

that I last saw h[illegible] alive on 1-8, 1927,

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Cardio renal

insufficiency

Arterio sclerosis with hypertension

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted

If not at place of death!

Did an operation precede death? no Date of [illegible] of wound.

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Radiograph

(Signed) S. Gennaro, M. D.

1-8, 1927 (Address) 1604 Linden ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem. Date of Burial Jan 11, 1927

20 UNDERTAKER: Geo E Keenan & Son ADDRESS 901 Hollins st

Geo E Keenan

Per [illegible]

Spec.—12-9-25—2 Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17736

CERTIFICATE OF DEATH

129 E 17735

REGISTERED NO.

1-PLACE OF DEATH Joseph A. Gutterlet

City of BALTIMORE: (No.) Sinai Hospital St. 10-14 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gutterlet, Joseph

(a) RESIDENCE NO. 1006 N. Central Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 4 mos. 20 ds. How long in U. S., if of foreign birth yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Jennie V. Gutterlet

6 DATE OF BIRTH (month, day, and year) August 18 1874

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or....min. |
|---|---|---|---|---|
| | 52 | 4 | 20 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Charles Gutterlet

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Welsh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Jennie V. Gutterlet

(Address) 1006 N. Central Ave

15 Filed JAN 10 1927, 19.. C. HUMPSON JONES, M. D. Registrar

Per

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/8/ 1927

17

I HEREBY CERTIFY, That I attended deceased from 12/21/ 1926, to 1/8/ 1927,

that I last saw him alive on 1/8/ 1927,

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Hypertension & Chronic Nephritis

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Lab findings

(Signed) John A. Aston, M. D.

Jan. 9, 1927 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery Date of Burial Jan. 11 1927

20 UNDERTAKER Henry Hoen & Son ADDRESS 1301 E Eager St

Spec.—1-10-21—M&T—15 0 Blks.

Force. ✓

E 17736 HEALTH DEPARTMENT—CITY OF BALTIMORE E 17736

CERTIFICATE OF DEATH. X 11-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Maryland General Hospital (St.) 11-24 (Ward) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kyle William Force Jr.

(a) RESIDENCE No. Beach + Williams Ave., Overlea, Md. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | W | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Florence Force

6 DATE OF BIRTH (month, day, and year) Nov 13, 1899

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 27 | 1 | 27 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer P. R. R. Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Mr. W. T. Force

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mrs Elderly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Florence Force

(Address) Overlea Md

Filed JAN 10 1927 C. HAMPSON JONES, M. D.

Per R.H. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1927

17 I HEREBY CERTIFY, That I attended deceased from 11-6-26, 1926, to Jan 9, 1927, that I last saw him alive on Jan 9, 1927, and that death occurred, on the date stated above, at 4:15 P. m.

The CAUSE OF DEATH* was as follows:

Perforated Gastric Ulcer

(duration) yrs. mos. 64 ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. 64 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 11-6-26

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. C. Zimmerman, M. D.

, 19 (Address) Maryland Gen'l Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem DATE OF BURIAL Jan 12 1927

UNDERTAKER Henry Stocks Sons ADDRESS 1301 E. Eager

Spec.—1-12-23—M&T—500 Bks.

E 17737

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

92-6 129

E 17737

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 622 Light ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dora Berg

(a) RESIDENCE NO. 622 Light ST., ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Berg.

6 DATE OF BIRTH (month, day, and year) July 24th. 1858

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs or ..... min. |
|---|---|---|---|---|
| | 68 | 5 | 16 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Emanuel ~~Germany~~ Cohen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Mannie Berg

(Address) 622 Light St

15 Filed JAN 10 1927 Per ..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany. 9th. 1927

17 I HEREBY CERTIFY, That I attended deceased from March 13, 1926, to Jan 9, 1927, that I last saw h[illegible] alive on Oct 19, 1926, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D. F. Herzog M.D. M. D.

1/10, 1927 (Address) 1305 N. Patterson Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Hebrew Friendship Cem. | 1/11/ 1927 |

20 UNDERTAKER David Sondheim ADDRESS 118-20 W. Fort. Royal.

[illegible] JONES, M. D.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 17738 135 ✓ E 17738

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St., 15-100 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob de Beer

(a) RESIDENCE NO. 1807 Ruxton Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. if of foreign birth 50 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fannie de Beer

6 DATE OF BIRTH (month, day, and year) Nov. 27 1855

| 7 AGE | Years | Months | Days | IF LESS than 1 day ____ hrs. or ____ min.. |
|---|---|---|---|---|
| | 71 | 1 | 12 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate,

(b) General nature of industry, business, or establishment in which employed (or employer) Broker

(c) Name of employer

9 BIRTHPLACE (city or town) ____

(State or country) Germany

PARENTS

10 NAME OF FATHER Moses de Beer

11 BIRTHPLACE OF FATHER (City or town) ____

(State or country) Germany

12 MAIDEN NAME OF MOTHER Martha Loventhal

13 BIRTHPLACE OF MOTHER (city or town) ____

(State or country) Germany

14 Informant Mrs. de Beer

(Address) 1807 Ruxton Ave.

15 JAN 10 1927 HARRISON JONES, M. Registrar

Per ____

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 Jan 9

17 I HEREBY CERTIFY, That I attended deceased from Dec 4 1926, to Jan 9 1927, that I last saw him alive on Jan 9 1927, and that death occurred, on the data stated above, at 5.15 P m.

The CAUSE OF DEATH* was as follows:

Pyelonephritis Bilateral Suppurative of Prostate

(duration) unknown yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) unknown yrs. mos ds.

18 Where was disease contracted if not at place of death? ____

Did an operation precede death? No Date of ____

Was there an autopsy? No

What test confirmed diagnosis? Blood chemistry Urinalysis

(Signed) M Hendrix, M. D.

, 19 (Address) University Hospital Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Bnai Hebrew Cem | 1/12/1927 |

20 UNDERTAKER Ward Sondheim ADDRESS 116-20 W. Mt. Royal Ave

very important. See instructions on back of c

Spec.—12-9-25—A Co.—200 Bks.

E 17739.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129 E 17739

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1414 St. [illegible] Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jesse Mobley

(a) RESIDENCE NO. 1414 Perma Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Negro | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Francis Mobley

6 DATE OF BIRTH (month, day, and year) 1882

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 45 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer odd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Aldreth Mobley

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Records

(Address)

Filed JAN 10 1927 C. HUMPSON JONES, M. D. Registrar

Ref. R.M.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 8 1927

17 I HEREBY CERTIFY, That I attended deceased from October 28 1926, to January 8, 1927, that I last saw him alive on January 8, 1927, and that death occurred, on the date stated above, at 9.50 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis & Insufficiency

Chronic Nephritis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) 6 yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Gross & laboratory

(Signed) [illegible] M. D.

Jan 9, 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Frederick Md Date of Burial 1/11/ 1927

20 UNDERTAKER D. Payne & Wright ADDRESS 128 W. Eldorado

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17740 E 17740

## CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1112 Hollins St ST. 18-29 WARD)

2-FULL NAME Alter Stumacher

(a) RESIDENCE No 1112 Hollins St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? 4 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rachael Stumacher

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years 84 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: old age

(b) General nature of Industry, business, or establishment in which employed (or employer): none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Russia

14 Informant: William Wally (Address) 1112 Hollins St

15 JAN 10 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/10 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1927, to Jan 10, 1927, that I last saw h[illegible] alive on Jan 10, 1927 and that death occurred, on the date stated above, at 9 9 m

The CAUSE OF DEATH* was as follows:

a Heart dilatation

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) hypocardiis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) M. D.

1/10, 1927 (Address) 710 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Kehren Rosedale — DATE OF BURIAL: 1/10 1927

20 UNDERTAKER: Jack Lewis — ADDRESS 1439 Eutaw

THIS IS VERY IMPORTANT—Please Answer Every Question

Spec.—1-10-21—M&T—1500 Blks.

E 17741

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

12-002

12 E 17741

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 401 Delaware Ave., ST. Respeburg. WARD) 16-42

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick N. Powell

(a) RESIDENCE No. 401 Delaware Ave., Respeburg ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie M. C. Powell

6 DATE OF BIRTH (month, day, and year) Sept. 30, 1846.

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 80 | 3 | 9 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Florist

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 10 years

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown Sweden

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Unknown

14 Informant Annie M. C. Powell
(Address) 401 Delaware Ave., Respeburg

15 Filed JAN 10 1927. C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 8, 1927.

17 I HEREBY CERTIFY, That I attended deceased from Nov 10, 1926, to Jan 8, 1927.

that I last saw h in alive on Jan 7, 1927.

and that death occurred, on the date stated above, at 11:50 A. m.

The CAUSE OF DEATH* was as follows:

Atrophic Cirrhosis of Liver
(non Alcoholic)

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) A. Lee Hubert, M. D.

1/10/ 1927 (Address) Mapleton & Belair Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — DATE OF BURIAL: Jan. 11, 19 27

20 UNDERTAKER: Frederick Loeschn & Son — ADDRESS: Fullerton, Md.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 17742

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17742

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Franklin Sq. Hosp. WARD 24-35

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Guntermann

(a) RESIDENCE. NO. 1432 E. Fort Ave WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Wh.

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced (or) WIFE of John Guntermann

6 DATE OF BIRTH (month, day, and year) Aug 9th 1884

7 AGE Years 42 Months 4 Days 24 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md (State or country)

PARENTS

10 NAME OF FATHER Wm J. Lang

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)

12 MAIDEN NAME OF MOTHER Emma Ozmon

13 BIRTHPLACE OF MOTHER (city or town) Balto Md (State or country)

14 Informant Mr. John F. Guntermann (Address) 1432 E. Fort

15 Filed OCT 10 1927 C. HARRISON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 8 1927

17 I HEREBY CERTIFY, That I attended deceased from June 1926 to Oct 8th 1927, that I last saw her alive on Oct 8th 1927, and that death occurred, on the date stated above, at 10 30 P m.

The CAUSE OF DEATH* was as follows:

Eclampsia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Amy Holoman, M. D.

, 19 (Address) 1703 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schwartz's Gen

DATE OF BURIAL 10/11 1927

20 UNDERTAKER F. Fenw McCully

ADDRESS 130 E Fort

Spec.—1-12-23—M&T—500 lbs.

E 17743 HEALTH DEPARTMENT—CITY OF BALTIMORE E 17743

CERTIFICATE OF DEATH.

57

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 623 Bartlett Ave ST. 9-46 WARD)

2-FULL NAME Georgiana Richards

(a) RESIDENCE No. 623 Bartlett Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William C. Richards

6 DATE OF BIRTH (month, day, and year): 10/9 1857

7 AGE

| Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|
| 69 | 2 | 28 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country): Balto Co Md.

PARENTS

10 NAME OF FATHER: Jotham German

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Co Md

12 MAIDEN NAME OF MOTHER: Julia Fowler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: William Richards

(Address) 623 Bartlett Ave

JAN 10 1927

HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 16, 1926, to Jan 7, 1927.

that I last saw h alive on Jan 7, 1927.

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Diabetis Coma

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Diabetes

(duration) yrs. 2 mos. 2 2½ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) H. E. Hoover, M. D.

Jan, 1927 (Address) 1301 N Pat Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: 1/11 1927

20 UNDERTAKER: George J. Ruth

ADDRESS: 1735 Harford Ave

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17744

## CERTIFICATE OF DEATH.

90

REGISTERED NO. E 17744

1-PLACE OF DEATH

City of BALTIMORE: (No. 806 E. North Ave St., 9-18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis Keim

(a) RESIDENCE NO. 806 E. North Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of XXXXXXX

6 DATE OF BIRTH (month, day, and year) 10/15 1874

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 52 | 2 | 23 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Constructing

(b) General nature of industry, business, or establishment in which employed (or employer) Engineer

(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md

(State or country)

PARENTS

10 NAME OF FATHER August Keim

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Elizabeth Keim

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore, Md

14 Informant Mrs. J. Francus Herbert

(Address) 806 E. North Ave

15 Filed JAN 18 1927 W. HAMPTON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 Jan 8/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Cardiac Failure-Valvular Insuff-iciency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. H. Falcon, M. D.
(Coroner)

1/10/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery Date of Burial 1/11 1927

20 UNDERTAKER George F. Ruth ADDRESS 1735 Hanford Ave

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

17745 E 17745

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2764 Alameda ST., 9-46 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick W Reinhold

(a) RESIDENCE NO. 2764 Alameda ST., 9 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. 4 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marie Reinhold

6 DATE OF BIRTH (month, day, and year) August 17, 1873

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 53 | 4 | 23 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker

(b) General nature of Industry, business, or establishment in which employed (or employer) Baking Co

(c) Name of employer Worked for Self

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Frederick W Reinhold

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Marie Schultz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Marie Reinhold
(Address) 2764 Alameda Ave

15 Filed 0 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 9, 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 5, 1926, to Jan. 9, 1927, that I last saw living on Jan. 9, 1927, and that death occurred, on the date stated above, at 5-35 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach.

(duration) yrs. 11 mos ds.

CONTRIBUTORY (Secondary) Carcinoma Stomach

(duration) yrs. 11 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? X Ray & Gastric Analysis

(Signed) H M Robinson M. D.

, 19 (Address) 705 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery — DATE OF BURIAL 1/12/ 1927

20 UNDERTAKER P. J. Fleming Inc - 1986 ADDRESS Lafayette Ave.

Spec.—1-10-21—M&T—1500 Bks.

E 17746

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17746

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST. 25 WARD) REGISTERED NO. 16

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John C. Maher

(a) RESIDENCE NO. 602 ~~Brookland Pk.~~ Brookwood ST. Hunting Ridge WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs 11 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louise Mrs. John C. Maher

6 DATE OF BIRTH (month, day, and year) Jan. 20, 1865

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 61 | 11 | 19 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Daniel Miller Co

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER John Peter Maher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Henrietta Craiter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant (Address) Hospital Records.

15 Filed 1 0 1927 C. HAMPSON JONES, M. D. Registrar

Per [illegible]

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 8 1927

17

I HEREBY CERTIFY, That I attended deceased from Dec. 31, 1926, to Jan. 8, 1927,

that I last saw him alive on Jan 8, 1927,

and that death occurred, on the date stated above, at 5:25 A m.

The CAUSE OF DEATH* was as follows:

Epidemic Grippe

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation 5 minutes

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Pk.

DATE OF BURIAL 1-11 1927

20 UNDERTAKER E & B Hark

ADDRESS 115 E West St

Spec.—6-9-19—H. P. Co.—1000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17747

## CERTIFICATE OF DEATH.

E 17747

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1425 Washington Blvd ST. 21 WARD. 161

REGISTERED NO. 21-29

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Harvey Jr.

(a) RESIDENCE. No. 1425 Washington Blvd ST., 21 WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed~~ or Divorced ~~(write the word)~~

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ———

6 DATE OF BIRTH (month, day, and year) Oct 22-1926

7 AGE: Years ——— Months 2 Days 19 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER William H Harvey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Levi Donnelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co Md

14 Informant William H Harvey (Address) 1425 Wash Blvd

15 Filed ... 1927 By ... Registrar

C. HAMPSON JONES, M. D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 22 1926 to Jan 10 1927.

that I last saw h— alive on Jan 8 1927.

and that death occurred, on the date stated above, at 5:00 a m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) ... yrs. 3½ mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ———

Did an operation precede death? No Date of ———

Was there an autopsy? ———

What test confirmed diagnosis? ———

(Signed) ... M. D.

(Address) 51 Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet

DATE OF BURIAL: 1-12 1927

20 UNDERTAKER: E T B Hale

ADDRESS: 115 E Mt St

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17748 E 17748

## CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 36 E. Cross St. 23 (Ward)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margarete Speer

(a) RESIDENCE NO. 36 E. Cross St., .....WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Speer

6 DATE OF BIRTH (month, day, and year) April 1st 1862

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs or ... min. |
|---|---|---|---|---|
| | 64 | 8 | 26 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work (Gen.) 037

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Austria-Hungary

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungary

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungary

14 Informant Anton Fabisch
(Address) 26 E Cross St

15 Filed 0 1927 C. HAMPSON JONES, M. D. Registrar
By AR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1. 8. 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. , 1926 , to Jan. 8 , 1927.
that I last saw h alive on Jan. 8 , 1927,
and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH was as follows:
Chronic Glomerulonephritis
Hypertension
(duration) 1 yrs. mos ds.
CONTRIBUTORY (Secondary) Hypertension Pneumonia
(duration) yrs. mos. 1½ ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) H. S. Marx M. D.
1. 9. 1927 (Address) 516 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross a&c — DATE OF BURIAL 1-11 1927

20 UNDERTAKER Ehrlich Hahn — ADDRESS 115 E West St

Spec.—12-9-25—A Co.—200 Bks.

# E 17749

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

11-00

# E 17749

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1041 Maldin St. 21-29 Ward)

2-FULL NAME Wm. J. Martin Jr.

(a) RESIDENCE NO. 1041 Maldin St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 9 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3-22-1925

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 1 | 9 | 17 18 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto Md.

PARENTS

10 NAME OF FATHER Wm J. Martin Jr.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Mary Moyn

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto Md

14 Informant Wm J. Martin Jr

(Address) 1041 Maldin St

15 Filed C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-9- 1927

17 I HEREBY CERTIFY, That I attended deceased from 1-8- 1927, to 1-9- 1927, that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 12:10 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Richard Dorsey, M. D.

, 19 (Address) 1041 Maldin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters — Date of Burial: 1-11-1927

20 UNDERTAKER: E & B Hale — ADDRESS: 115 E North Ave

Spec.—12-9-25—A Co.—200 Bks.

E 17750

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17750

## CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Church Home & Infirmary

City of BALTIMORE: (No. ____ St., 6 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Myles P. Whalen

(a) RESIDENCE NO. Bengies St., Maryland. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widower |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Whalen.

6 DATE OF BIRTH (month, day, and year) April 5-1849

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 77 | 9 4 | 3 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Ireland.

PARENTS

10 NAME OF FATHER William Whalen

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth McCabe

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Mrs. Rose A. Byrnes.

(Address) Bengies Md.

Filed 1927 C. HAMPSON JONES, M. D. Registrar

By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 8th 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 2nd, 1927, to Jan 8th, 1927, that I last saw him alive on Jan. 8th, 1927, and that death occurred, on the date stated above, at 4:08 P. m.

The CAUSE OF DEATH* was as follows:

Uremia

Chr. diffuse nephritis

Myocarditis Terminal Broncho-pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Senile gangrene of Rt. Leg

Amputation (duration) yrs. 1 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of Jan. 4th 1927

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) Merrill T. Felton, M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

New Cathedral Cem. Jan. 11 1927

20 UNDERTAKER Lilly & Zeiler ADDRESS 403 S. Wolfe St

Spec.—12-9-25—A Co.—200 Bks.

E 17751

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17751

## CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. the Church Home & Infirmary St. 26-37 Ward)

2-FULL NAME Mrs Helen Wagowicz

(a) RESIDENCE NO. 307 S. 14th St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F M.

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Michial

6 DATE OF BIRTH (month, day and year): Feb. 1885

7 AGE: 41 Years 11 Months - Days IF LESS than 1 day.....hrs. or.....min.

42

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: House Work
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: at Home

9 BIRTHPLACE (city or town) (State or country): Chuchu Slovaka

PARENTS
10 NAME OF FATHER: John Kudela
11 BIRTHPLACE OF FATHER (city or town) (State or country): Slovaka
12 MAIDEN NAME OF MOTHER: Miller
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Slovaka

14 Informant (Address): Madline Wagowich 307 S 14th St

C. HAMPSON JONES, M. D. Registrar

D 1927 Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 Jan 9 1927.

17 I HEREBY CERTIFY, That I attended deceased from 1-4-27, 1927, to Jan 9, 1927, that I last saw h.. alive on Jan 9 4, 1927, and that death occurred, on the date stated above, at 9.50 a m.

The CAUSE OF DEATH* was as follows: Acute Salpingitis, bilateral

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) General peritonitis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Jan 4 1927.

Was there an autopsy? No

What test confirmed diagnosis? Operation. (over)

(Signed) Henry S P Wilson Jr MD, M. D.

, 19 (Address) The Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 1/12 1927

20 UNDERTAKER H W Ozazewski ADDRESS 1930 Eastern

St Stanislaus

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17752

E 17752

## CERTIFICATE OF DEATH.

REGISTERED NO. 27-53 161-001

1-PLACE OF DEATH Woman's Hospital

CITY OF BALTIMORE: (NO. ..... ST. 27-53 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Anderson

(a) RESIDENCE NO. 320 Hawthorne Rd ST Roland Park

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ——

6 DATE OF BIRTH (month, day, and year) Jan. 9, 1927.

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | | | Two minutes | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Paul S. Anderson

11 BIRTHPLACE OF FATHER (city or town) N. J.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Virginia Lyon

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Robt H. Lyon
(Address) 320 Hawthorne Rd.

C. HAMPSON JONES, M. D.
Registrar

0 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 9, 1927. to Jan. 9, 1927.

that I last saw him alive on Jan. 9, 1927.

and that death occurred, on the date stated above, at 7.20 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity (6 mos)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acute hydramnios

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? No Date of ——

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) R. H. Kroh, M. D.

, 19 (Address) Woman's Hospital, Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL JAN 10 1927

20 UNDERTAKER — ADDRESS

JOHNS HOPKINS HOSPITAL

Deputy Commissioner Health

JAN 10 1927

Spec.—12-9-25—A Co.—200 Bks.

E 17753

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 17753

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mercy Hospital

City of BALTIMORE: (No. ____ St. 21-29 Ward)

REGISTERED NO. ____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Smith

(a) RESIDENCE NO. 811 Pratt St. Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 45 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): ✓

(State or country)

PARENTS

10 NAME OF FATHER ✓

11 BIRTHPLACE OF FATHER (city or town) ✓

(State or country)

12 MAIDEN NAME OF MOTHER ✓

13 BIRTHPLACE OF MOTHER (city or town) ✓

(State or country)

14 Informant: JOHNS HOPKINS HOSPITAL

(Address)

15 Filed: JAN 10 1927 Registrar

0 1927 093

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan 3 1927 to Jan 7 1927,

that I last saw h[illegible] alive on Jan 7, 1927,

and that death occurred, on the date stated above, at 3:45 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Chronic Nephritis & Uremia

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? ____ Date of ____

Was there an autopsy? ____

What test confirmed diagnosis? ____

(Signed) [illegible], M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

Date of Burial: JAN 10 1927 19

20 UNDERTAKER

ADDRESS

Commissioner Health.

Spec.—1-10-21—M&T—1500 Bks.

E 17754

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 17754

REGISTERED NO. 11-24-50

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Gen'l Hosp. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura M. Rosier

(a) RESIDENCE NO. Parkton, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced (~~HUSBAND of~~ or:) WIFE of James M. Rosier.

6 DATE OF BIRTH (month, day, and year) Dec. 15, 1865

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 61 | | 25 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Wm Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Eliza Riley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hospital Record. (Address)

15 1927 C. HAMPSON JONES, M. D. Registrar. Per RCH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/10 1927

17 I HEREBY CERTIFY, That I attended deceased from 1/4, 1927, to 1/10, 1927, that I last saw ~~HER~~ alive on 1/10, 1927, and that death occurred, on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:

Abdominal Growth (Undetermined)

Secondary anemia

(duration) ? yrs. mos. dy.

CONTRIBUTORY (Secondary) Pulmonary edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Refused

What test confirmed diagnosis? Clinical

(Signed) C. Jimmerman, M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Maryland Sem'y Med — DATE OF BURIAL: Jan. 12, 1927

20 UNDERTAKER: Fortenbaker Funeral Home — ADDRESS: Med Sem'y Med.

Spec.—1-12-23—M&T—500 Bks.

E 17755

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17755

## CERTIFICATE OF DEATH.

143-0

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Baltimore Gen. Hosp. STREET 40-11 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Thelma Crawley

(a) RESIDENCE NO. 3604 - Eden Place St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Clarence Crawley

6 DATE OF BIRTH (month, day, and year): 1/22/1909

7 AGE: 17 Years | 11 Months | 15 Days | If LESS than 1 day, hrs. or min.

18

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Lewis Larsen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Denmark

12 MAIDEN NAME OF MOTHER: Hyonah Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant (Address): West Baltimore Gen. Hospital

15 Date: 1 0 1927 C. HAMPSON JONES, M. D. Registrar

Per RCH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/7 19 27

17

I HEREBY CERTIFY, That I attended deceased from 10/24 19 26 to 1/7 19 27

that I last saw her alive on 1/7 19 27

and that death occurred, on the date stated above, at 6:00 P.M.

The CAUSE OF DEATH* was as follows:

Incomplete abortion (Criminal)

(duration) yrs. mos. 2 ds. 8

CONTRIBUTORY (Secondary) Bacterial endocarditis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 12/10/26

Was there an autopsy? yes

What test confirmed diagnosis? autopsy Gram's stain

(Signed) Frances K. Larsen, M. D.

1/7, 1927 (Address) West Baltimore Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: 1/11 1927

20 UNDERTAKER: George J. Ruth

ADDRESS: 1730 Harford Ave

Spec.--1-12-23—M&T—500 Bks.

17756

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17756

## CERTIFICATE OF DEATH.

14 57

1-PLACE OF DEATH Homewood Hospital

CITY OF BALTIMORE: (No. 2724 N. Charles St. ST., 13 WARD)

REGISTERED NO. 13-57

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Grace Yeagle

(a) RESIDENCE No. 2130 Wyoming Ave ST., 13 WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Lawrence G. Yeagle

6 DATE OF BIRTH (month, day, and year): July 9. 1890

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 36 | 5 | 29 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Wife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Geo A Burgee

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Co. Md

12 MAIDEN NAME OF MOTHER: Sarah A. Harry

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant (Address): L. G. Yeagle 2130 Wyoming Ave

15 Filed JAN 9 1927 C. HAMPSON JONES, M. D. Registrar

Per ACS

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 4. 1927. to Jan 7. 1927.

that I last saw h[illegible] alive on Jan 7. 1927.

and that death occurred, on the date stated above, at 5-30 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism

Puerperal

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary): Not remembered

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) H. Brantigan M. D.

1-7. 1927 (Address) 3543 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge

DATE OF BURIAL: Jan. 11 1927

20 UNDERTAKER: Horace H. Burgee

ADDRESS: 3631 Falls Road

Spec.—1-12-23—M&T—500 Blks.

E 17757

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17757

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH West Baltimore General Hospital REGISTERED NO. 16-68

CITY OF BALTIMORE: (No. Raynor and Dukeland ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barnard Hively

(a) RESIDENCE: NO. Fizzelsburg, Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kate Hively

6 DATE OF BIRTH (month, day, and year) unknown

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 59 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cattle Dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Sterling Hively

(Address) Westminster Md

15 Filed JAN 10 1927, 19 C. HAMPSON JONES, M. D.

Per AKS Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/10 1927

17 I HEREBY CERTIFY, That I attended deceased from 1/8, 1927, to 1/10, 1927

that I last saw him alive on 1/10, 1927

and that death occurred, on the date stated above, at 5:45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical findings

(Signed) Benjamin Miller, M. D.

, 19 (Address) W. B. G. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, REMOVAL OR CREMATION Carroll County DATE OF BURIAL

Burst Cemetery Jan. 13 1927

20 UNDERTAKER C. O. Swartzbaugh ADDRESS Sandy Town Md

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17758

## CERTIFICATE OF DEATH.

126

E 17758

1-PLACE OF DEATH Union Memorial Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 33 E. Calvert ST. 1724 WARD

2-FULL NAME Ruth E. Roller

(a) RESIDENCE NO. Redwood, Md ST. ..... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ~~3~~ yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Feb. 21, 1923.

7 AGE

| Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|
| 3 | 10 | 14 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Chester A. Roller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Penna.

12 MAIDEN NAME OF MOTHER: Rosie B. Naylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland.

14 Informant: C. R. Roller

(Address): Redwood Md.

15 Filed JAN 11 1927, 19 .... Per .... Registrar

C. HAMPSON JONES, M. D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 10, 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 6, 1927, to Jan 10, 1927, that I last saw h— alive on Jan. 13, 1927 and that death occurred, on the date stated above, at 12 05 A m.

The CAUSE OF DEATH* was as follows:

Pneumococcic peritonitis

(duration) ... yrs. ... mos 1 2 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Jan 7, 1927.

Was there an autopsy? no

What test confirmed diagnosis? Operation + culture

(Signed) R. J. Bellord —, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Butler Balto Co

DATE OF BURIAL: Jan 11 1927

20 UNDERTAKER: Cheswouth & Son

ADDRESS 3417 Chestnut Ave

E. 17759

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17759

## CERTIFICATE OF DEATH.

REGISTERED NO. 16

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 7th St. near 4 ave ST., Fapp Bld WARD

2-FULL NAME George London

(a) RESIDENCE NO. 7th St near 4th ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 7-1926

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | — | 5 | 2 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. City

PARENTS

10 NAME OF FATHER George London

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C

12 MAIDEN NAME OF MOTHER Gladys Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant George London
(Address) 7th St. near 4 ave

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar
19 Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1927 to 1927, that I last saw h[illegible] alive on 1927, and that death occurred, on the date stated above, at 10 30 P m.

The CAUSE OF DEATH* was as follows:

acute Diarrhoea

(duration) yrs mos ds.

CONTRIBUTORY (Secondary) Artificial Feeding

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. D.

, 19 (Address) 1240 S Clark

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Calvary Cemetery

DATE OF BURIAL Jan 11 1927

20 UNDERTAKER John H. Tradin

ADDRESS 142 45 Hillen St

Spec.—12-9-25—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17760

## CERTIFICATE OF DEATH.

129

E 17760

1-PLACE OF DEATH Mercy Hospital

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No._____ St. 4-25 Ward)

2-FULL NAME Florence Brown

(a) RESIDENCE NO. 17 W. Mulberry St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Walter Brown

6 DATE OF BIRTH (month, day, and year): American 1873

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| 53. | 54 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer): Fraternity Bldg.

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Unknown

14 Informant Walter Brown

(Address) 17 W Mulberry St

15 Filed 1 1 1927 Per _____ C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8 · 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1927, to Jan 8, 1927, that I last saw h.. alive on Jan 8, 1927, and that death occurred, on the date stated above, at 7:30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Cardiac Degeneration

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) Chronic Nephritis - Uremia

(duration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted if not at place of death?_____

Did an operation precede death? ___ Date of ___

Was there an autopsy? ___

What test confirmed diagnosis? ___

(Signed) H. H. Mills, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — Date of Burial: 1/11/27

20 UNDERTAKER: Mrs. P. H. Elliott — ADDRESS: 1725 Ashland Ave.

Spec.—1-12-23—M&T—500 Blks.

# E 17761 HEALTH DEPARTMENT—CITY OF BALTIMORE

+6 E 17761

## CERTIFICATE OF DEATH

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 8 Glenwood Ave ST., (Ward) 27

2-FULL NAME Cynthia Dunn

(a) RESIDENCE No. 8 Glenwood Ave ST., 27 WARD 27

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Alonza L. Dunn

6 DATE OF BIRTH (month, day, and year): Apr. 20, 1861

7 AGE: 66 Years | Months 8 | Days 9 | If LESS than 1 day.....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Adam Fries

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mrs. R. C. Shipley

(Address) 8 Glenwood Ave

Filed 1-1-1927 19 Per C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1-9- 1927

17

I HEREBY CERTIFY, That I attended deceased from Nov. 3, 1926, to Jan 9, 1927,

that I last saw her alive on Jan 8, 1927,

and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma uteri with metastasis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. L. Williamson, M. D.

1/9, 1927 (Address) Cole Ave & Baltimore Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem — DATE OF BURIAL: Jan 12 1927

20 UNDERTAKER: Geo M. Fink & Son — ADDRESS: 811 N Howard

Spec.—1-12-23—M&T—300 Blks.

19892

E 17762

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17762

## CERTIFICATE OF DEATH.

REGISTERED NO. 57

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (NO. 15-65 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa M. - Lohmeyer

(a) RESIDENCE NO. 3204 Vickers Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. 2 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | white | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 25 79

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 47 | 2 | 15 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Artists Supplies

(b) General nature of industry, business, or establishment in which employed (or employer) Arts

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md -

PARENTS

10 NAME OF FATHER A. Lohmeyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger -

12 MAIDEN NAME OF MOTHER A. Bachr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger -

14 Informant Records - JOHNS HOPKINS HOSPITAL

(Address)

15 Filed JAN 1 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 , 1927 to Jan 10 , 1927.

that I last saw h er alive on Jan 10 1927

and that death occurred, on the date stated above, at 9.25 A. M.

The CAUSE OF DEATH* was as follows:

Cellulitis of Right leg.
(streptococcus)

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? Yes -

What test confirmed diagnosis? Autopsy.

(Signed) E. Cowles Andrus, M. D.

, 19 (Address) Johns Hopkins Hospital -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Jordan Park bur

DATE OF BURIAL Jan 13 1927

20 UNDERTAKER W M Routson

ADDRESS 2238 N Monroe

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17763

## CERTIFICATE OF DEATH.

31 E 17763

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals (T.B.) St. 4-25 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Peake

(a) RESIDENCE NO. 115 N. Green st. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1881

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 45 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Peter Peake

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Alice Arminger

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Hospital Records

(Address)

Filed JAN 11 1927 HAMPSON JONES, M. D.

Per Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 January 9, 1927

17

I HEREBY CERTIFY, That I attended deceased from July 28, 1926, to January 9, 1927,

that I last saw h... alive on January 9, 1927,

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial Asthma

(Duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. E. Latterus, M. D.

1-10-27 (Address) Baltimore City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Date of Burial Jan 11 1927

UNDERTAKER H. M. Rowton

ADDRESS 2238 N Howard

1-12-23—M&T—100 Bks.

E 17764 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

9° E 17764

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PLACE OF DEATH

OF BALTIMORE: (No.) 508 Cathedral ST., 11-25 WARD)

FULL NAME Albert [redacted] Andre

RESIDENCE NO. 508 Cathedral ST., ..... WARD .....

(Usual place of abode)

of residence in city or town where death occurred Lifetime (If non-resident give city or town and State)

ds. How long in U. S., If of foreign birth? yrs. mos ds.

PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE: ale White

5 Single, Married, Widowed, or Divorced (write the word): Divorced

rried, widowed, or divorced SBAND of ) WIFE of

OF BIRTH (month, day, and year) Aug 3-1865

| Years | Months | Days | If LESS than 1 day, ....hrs. or ....min. |
|---|---|---|---|
| 61 | 5 | 5 | |

PATION OF DECEASED rade, profession or cular kind of work Watchman

General nature of industry, ness, or establishment in h employed (or employer) 06 2/

Name of employer

HPLACE (city or town) or country) Balto Md

AME OF FATHER Christopher Andre

RTHPLACE OF FATHER (city or town) tate or country) Germany

AIDEN NAME OF MOTHER Johanna Andre

RTHPLACE OF MOTHER (city or town) tate or country) Germany

ormant Thos Luder Andre

ddress) 1140 Eastern Ave

C. HARRISON JONES, M.

1927 Por ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8th 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above. (Inquest, autopsy or inquiry.)

The CAUSE OF DEATH* was as follows:

Acute Cardiac dilatation

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. C. Riley, M. D. (Coroner)

Jan 9, 1927 (Address) 1639 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) 2 or 3 minutes In the

At place of death ..... yrs., ..... mos., ..... ds. State ..... yrs., ..... mos., ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL Jan 11 1927

20 UNDERTAKER Chas H. Grass — ADDRESS 1101 Mt Royal Ave

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17765

## CERTIFICATE OF DEATH.

77-56 89

E 17765

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4754 Pimlico Road ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josiah Zeph

(a) RESIDENCE NO. 4754 Pimlico Road ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Elizabeth L. Hall

6 DATE OF BIRTH (month, day, and year) Feby. 10, 1854

| 7 AGE | Years | Months | Days | If LESS than 1 day, .... hrs or .... min. |
|---|---|---|---|---|
| | 72 | 10 | 29 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Asst. Manager

(b) General nature of industry, business, or establishment in which employed (or employer) Biscuit Co.

(c) Name of employer Loose Wiles Co

9 BIRTHPLACE (city or town) (State or country) Carroll Co. Md

PARENTS

10 NAME OF FATHER Peter Zeph

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Elizabeth L. Zeph (Address) 4754 Pimlico Road

15 Filed JAN 11 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1 — 9 — 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 8th, 1927, to Jan 9th, 1927, that I last saw him alive on Jan 9th, 1927, and that death occurred, on the date stated above, at 12:15 P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris (duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) arteriosclerosis (duration) 6 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Eugene Douglas M. D.

1/10, 1927 (Address) 3043 St. Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL, Druid Ridge Cem. DATE OF BURIAL Jan. 12 1927

20 UNDERTAKER Harry W. Ehlen ADDRESS 1944 W. North Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

E 17766

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17766

## CERTIFICATE OF DEATH.

Registered No.: 24 129

1-PLACE OF DEATH

City of BALTIMORE: (No. 307 S Ann St ..... St. ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Genove Lawinska

(a) Residence No. 307 S Ann St ..... St., ..... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

| 3-SEX. | 4-COLOR OR RACE. | 5-Single, Married, Widowed, or Divorced. (Write the word.) |
|---|---|---|
| F | W | Married |

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Casimier Lawinski

6-DATE OF BIRTH (month, day and year) Jan 3 1906

7-AGE. 21 yrs. — mos. 6 ds. If LESS than 1 day, ....hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) Wheeling (State or Country), West Virginia

PARENTS.

10-NAME OF FATHER, John Pasienski

11-BIRTHPLACE OF FATHER (city or town) Poland (State or Country),

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER (city or town) Poland (State or Country),

14- (Informant) Mr Casimier Lawinski

(Address) 307 S Ann St

15- Filed ..... 192 ..... C. HAMPSON JONES, M. D. Registrar.

JAN 11 1927 Per GK

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan. 9, 1927

17- I HEREBY CERTIFY, That I attended deceased from Jan 7 1927 to Jan 9 1927

that I last saw her alive on Jan 9, 1927

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Puerperal Eclampsia

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) ..... yrs. ? mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P. S. & S.

(Signed) John J. Kluge M. D

, 19 (Address) 462 Eastern Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

| 19-PLACE OF BURIAL, CREMATION OR REMOVAL. | DATE OF BURIAL. |
|---|---|
| Holy Rosary | Jan 13 1927 |
| UNDERTAKER. | ADDRESS |
| John M Weber | 1803 Bank St |

Cor.—12-9-25—A Co.—200 Bks.

James & Collins

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17767

CERTIFICATE OF DEATH.

89 E 17767

1-PLACE OF DEATH

City of BALTIMORE: (No. 735 N Eutaw St., 4-26 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Samuel Collins

(a) RESIDENCE NO. 735 N Carrollton St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | Col | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha Collins

6 DATE OF BIRTH (month, day, and year) 1857

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| about | 77 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Gas Meter

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland

(State or country)

PARENTS

10 NAME OF FATHER Samuel Collins

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Guyanna ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Martha Collins

(Address) 246 Bowers Court

Filed NOV 1 1927 19 C. HAMPSON JONES, M. D. Registrar

By RRS

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/27 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) 1 hour yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Samuel T. Truitt M. D.
(Coroner)

, 19 27 (Address) 3328 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Dec - Loudon Cemetery Jan 12, 1927

UNDERTAKER Mrs. Kate R. Williams

ADDRESS 327 N Schroeder St

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17768

1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

1927

89

REGISTERED NO. E 17768

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1829 W Lexington ST. 20 WARD)

2-FULL NAME Joseph A Spreiner

(a) RESIDENCE NO. (Usual place of abode) 1829 W Lexington. WARD

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Katherine D Spreiner

6 DATE OF BIRTH (month, day, and year): Mch 19 1871

7 AGE — Years: 55 — Months: 9 — Days: 20 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Balt City

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Adam Spreiner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Fisherdick

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Mrs Spreiner 1829 W Lexington St

JAN 11 1927 H. HAMPSON JONES, M.D. Registrar.

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 9. 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 8. 1927, to Jan. 9 1927, that I last saw h[illegible] alive on Jan. 9. 1927, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Death was due to Angina Pectoris

Sudden (duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Not Known (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chesley Lee Davis, M. D.

Jan 10 1927 (Address) 824 N. Eutaw ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem

DATE OF BURIAL: 1/12 1927

20 UNDERTAKER: Geo A Tarby

ADDRESS: Fulton & Lafayette

pec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17769 E 17769

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Jan Second Hospital REGISTERED NO. 2027

CITY OF BALTIMORE: (No.) Fayette (ST., AVE., or ROAD) Patterson (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Catherine M Goldsborough

(a) RESIDENCE No. 190 W Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced HUSBAND of or) WIFE of: W Goldsborough

6 DATE OF BIRTH (month, day, and year): Feb 18 1845

7 AGE: Years 81 Months 2 Days 22 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Wm Gallagher

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary Considine

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): W Goldsborough 190 W Fayette

15 Filed JAN 11 1927 19 Per K M Registrar

C. HAMPSON JONES, M. D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 10 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 5, 1927, to Jan 10, 1927.

that I last saw he/she alive on Jan. 9, 1927,

and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Uremia

Cerebral Edema

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Geo. D. Lehman, M. D.

19 (Address) Jan Second Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodland Cem DATE OF BURIAL: 1/12/27

20 UNDERTAKER: Geo A Jacoby Sutton & Fayette ADDRESS

spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE E 17770

## CERTIFICATE OF DEATH.

E 17770

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital 12 WARD)

REGISTERED NO. 12-4945

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Otto Lohmeyer

(a) RESIDENCE NO. 3333 N. Charles ST. 12 WARD Resident

(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? 52 yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widowed |

a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Lee Webb Lohmeyer

6 DATE OF BIRTH (month, day, and year) Nov 1 1858

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 68 | 2 | 9 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Purchasing Agent

(b) General nature of industry, business, or establishment in which employed (or employer) Various Lines

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Braunschweig Germany

PARENTS

10 NAME OF FATHER Ernest Lohmeyer

11 BIRTHPLACE OF FATHER (city or town) Braunschweig (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Ackman

13 BIRTHPLACE OF MOTHER (city or town) Braunschweig (State or country) Germany

14 Informant Arthur Lohmeyer (Address) Columbus Ohio

15 Filed JAN 7 1927, 19 C. HAMPSON JONES, M.D. Registrar Per RJC

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 10. 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 27, 1926, to Jan 10, 1927, that I last saw him alive on Jan 10, 1927, and that death occurred, on the date stated above, at 3 40 A m.

The CAUSE OF DEATH* was as follows:

malignancy ~~of~~ retroperitoneal gland.

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) uremia with anuria

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy & section

(Signed) Raymond T. Jo Riveston, M. D.

, 19 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL Jan-11 1927

19 UNDERTAKER STEWART & HOWEN COMPANY

ADDRESS 108 W. NORTH AVE

Spec.—12-9-25—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17771 -001

## CERTIFICATE OF DEATH.

E 17771 REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 12-50 St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Gootee

(a) RESIDENCE NO. 2525 N. Calvert St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1837

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 90 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER John Gootee

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Small

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Records

(Address)

Filed JAN 11 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 10 1927

17

I HEREBY CERTIFY, That I attended deceased from December 14, 1926, to January 10, 1927,

that I last saw h.. alive on January 10, 1927,

and that death occurred, on the date stated above, at 9:15 A. M.

The CAUSE OF DEATH* was as follows:

Senility

Cerebral Sclerosis

(duration) ?yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Haemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? General Laboratory

(Signed) C. Hampson Jones, M. D.

Jan 14 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Middletown - Delaware Date of Burial Jan 13 1927.

20 UNDERTAKER, STEPHEN COMPANY (WILLIAM F. WOOLLEN, Successor) ADDRESS 108 W. NORTH AVE.

Spec.—7-17-26—A Co.—200 Bks.

Kochane

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 17772

## CERTIFICATE OF DEATH

E 17772

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2340 Fleet St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie Kochane

(a) RESIDENCE NO. 2340 Fleet St. Ward 1

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Kochane

6 DATE OF BIRTH (month, day, and year) 1898

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|---|
| | 28 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER Joseph Crisp

11 BIRTHPLACE OF FATHER (city or town) Balto. Md.

(State or country)

12 MAIDEN NAME OF MOTHER Margt Brockel

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto. Md.

14 Informant Estelia A. Kane (sister)

(Address) 2340 Fleet St.

15 Filed ..... 19 ..... Por .....

C. HARRISON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8th 1927

17 I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h.. alive on ..... 19.....

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows

Cirrhosis Pancreas

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Gross & Microscopic

(Signed) ..... M. D.

. 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cemetery

Date of Burial: Jan 11th 1927

20 UNDERTAKER: Lilly & Sons

ADDRESS: 4038 Wolfe St

JAN 11 1927

Spec.—1-12-23—M&T—500 Bks.

1985-41

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17773

## CERTIFICATE OF DEATH.

38

E 17773

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO. 11-24

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. 11 WARD)

2-FULL NAME Jas. Peter Jenkins

(a) RESIDENCE NO. 908 McCulloh ST. City WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) — 1899

| 7 AGE Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|
| 27 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Wm Jenkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va -

12 MAIDEN NAME OF MOTHER Emma Cork

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Records -

(Address) JOHNS HOPKINS HOSPITAL

Filed JAN 7 1927, 19 C. HAMPSON JONES, M. Registrar

By .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec. 31, 1926, to Jan - 7, 1927, that I last saw h alive on Jan - 7, 1927 and that death occurred, on the date stated above, at 6 45 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis, Pyelonephritis, Hypertension, Uraemia & Coma

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Syphilis, Gonorrheal Arthritis, Cystitis

Epilepsy (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Morton Sherry, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL Jan 11 19 27

UNDERTAKER D. Jno. M. Johnson

ADDRESS 1284 Ethan St

Spec.—1-10-21—M&T—1500 Bks.

17774

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

27 E 17774

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 517 N. Streeper St

CITY OF BALTIMORE: (No. ) ST., 7-11 WARD)

2-FULL NAME Josephine Karas

(a) RESIDENCE NO. 517 N. Streeper ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? 34 yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wenceslaw

6 DATE OF BIRTH (month, day, and year) June 16 1871

7 AGE Years 55 Months 8 Days 23 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Joseph Sedlak

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Helen Waldt

(Address) 517 N. Streeper St.

15 Filed [illegible] 19 [illegible] Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 11 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan 4, 1927, to Jan. 11, 1927, that I last saw h[illegible] alive on Jan. 10, 1927, and that death occurred, on the date stated above, at 7:10 a.m.

The CAUSE OF DEATH* was as follows:

Pleurisy, hypostatic pneumonia, myocarditis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Mitral insufficiency

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) L. C. Sabbrad M. D.

, 19 (Address) 447 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Jan 13 1927

20 UNDERTAKER Frank Erackson — ADDRESS 1906 Eastlond

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17775

## CERTIFICATE OF DEATH.

90 E 17775

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. _____ St., 3-5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Crivello

(a) RESIDENCE NO. 102 Albemarle St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

3a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1865

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 62 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Italy

PARENTS

10 NAME OF FATHER Romonan Crivello

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Italy

12 MAIDEN NAME OF MOTHER Anne Marie —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Italy

14 Informant Records

(Address)

15 Filed JAN 1 1927 HAMPTON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: month, day, and year) January 6 1927

17 I HEREBY CERTIFY, That I attended deceased from January 6, 1927, to January 7, 1927, that I last saw him alive on January 7, 1927, and that death occurred, on the date stated above, at 9:00 A. m.

The CAUSE OF DEATH* was as follows:

Arterial Sclerosis

Chronic Myocarditis & Insufficiency

(duration) yrs. ? mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? General & Laboratory

(Signed) D. Hooper Lunt, M. D.

Jan 10. 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart — Date of Burial 1/11 1927

20 UNDERTAKER J. J. Daley Son — ADDRESS 1318 Light St

Spec.—1-12-23—M&T—500 Blks.

Kleina

# E 17776 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 17776

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 816 N Madeira ST. 7-12 (WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ..... Frank J Kleina

(a) RESIDENCE No. 816 N Madeira ST. ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widower |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Barbara Kleina

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min |
|---|---|---|---|---|
| | 63 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Vojtech Kleina

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Jos. Kleina

(Address) 816 N Madeira St

JAN 11 1926 HAMPSON JONES, M.D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 5, 1927, to Jan 10, 1927, that I last saw him alive on Jan 10 1927 and that death occurred, on the date stated above, at 6:00 A m

The CAUSE OF DEATH* was as follows:

Cardiac Asthma

Myocardial Degeneration

Mutral & Aortic Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) Joseph Polesny, M. D.

, 19 (Address) 2200 E Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Jan 13 1927

X UNDERTAKER Frank Evodden — ADDRESS 1906 E Baltimore

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17777

E 17777

## CERTIFICATE OF DEATH

REGISTERED NO. 46

1-PLACE OF DEATH

City of BALTIMORE: (No. 2501 Madison Ave St., 13-59 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marjorie R Lefevre

(a) RESIDENCE NO. 2501 Madison Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: white

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~ (write the word): widow

5a If ~~married~~, widowed, ~~or divorced~~ ~~HUSBAND of~~ (or) WIFE of: Joseph Lefevre

6 DATE OF BIRTH (month, day, and year): Dec 14, 1894

7 AGE: Years 32 Months Days 24

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 0

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Ridgely

(State or country): Md

PARENTS

10 NAME OF FATHER: Mr. H. H. Richards

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Md

12 MAIDEN NAME OF MOTHER: Nellie E Sands

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Md

14 Informant: Mrs. M. E. Richards

(Address): 501 Madison Ave

15 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: Jan 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 5, 1926, to Jan 11, 1927, that I last saw h alive on Jan 11, 1927, and that death occurred, on the date stated above, at 6, a.m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

Don't Know yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Womb

(Duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Don't Know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) Leroy Kelly M. D.

. 19 (Address) 2507 N Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Wyoming, Md

Date of Burial 1/13/27

20 UNDERTAKER: Wm Lord Sons

ADDRESS

pec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17778 E 17778

## CERTIFICATE OF DEATH.

REGISTERED NO. 24409

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2004 St. Paul St. 12-14 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen L Musgiller

(a) RESIDENCE NO. 2004 St. Paul ST., WARD

(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, ~~Widowed~~, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: John B Musgiller

6 DATE OF BIRTH (month, day, and year): Sept 15 1863

7 AGE: Years 63 Months 3 Days 25 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Talbot Co Md

PARENTS

10 NAME OF FATHER: John L Greenhall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Talbot Co Md

12 MAIDEN NAME OF MOTHER: Elmonia

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Talbot Co Md

14 Informant: John B Musgiller (Address) 2004 St Paul St.

15 Filed JAN 12 1927 C. HAMPSON GORE, M. D. Registrar

Temple Gardens Asst. Clerk

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 10 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1926, to Jan 10 1927.

that I last saw h- alive on Jan 9 1927.

and that death occurred, on the date stated above, at 12 45 a m.

The CAUSE OF DEATH* was as follows:

arteriosclerosis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary): cerebral hemmorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) J Frederick Lentz, M. D.

1/11, 1927 (Address) Temple Gardens.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fair Lincoln Cem

DATE OF BURIAL: Jan 12 1927

20 UNDERTAKER: W Chambers

ADDRESS: 502 E North Ave

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17779

## CERTIFICATE OF DEATH.

90

E 17779

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. 19-28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William E. Briggs

(a) RESIDENCE NO. 1810 Wilkins Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~the late~~ Mary E Briggs

6 DATE OF BIRTH (month, day, and year) May 17 1861

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| 65 | 66 | 8 | 23 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) New Jersey

PARENTS

10 NAME OF FATHER William E. Briggs

11 BIRTHPLACE OF FATHER (city or town)

(State or country) New Jersey

12 MAIDEN NAME OF MOTHER Ellen

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) New Jersey

14 Informant

(Address)

1 1927 C. HAMPSON JONES, M. D.

Per Records Clerk Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 10 1927

17 I HEREBY CERTIFY, That I attended deceased from December 14, 1926, to January 10, 1927, that I last saw him alive on January 9, 1927, and that death occurred, on the date stated above, at 3:00 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis & Arteriosclerosis

Hypertension

Residual left Hemiplegia (Thrombotic)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Laboratory

(Signed) C. Hooper Linell, M. D.

Jan 14 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Date of Burial 1/17/27

20 UNDERTAKER Ellen Leo & Co ADDRESS 502 E. Lanvale St

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17780

## CERTIFICATE OF DEATH.

177 E 17780

1-PLACE OF DEATH

City of BALTIMORE: (No. Homewood Hospital St. 26-37 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hazel Anna Elton

(a) RESIDENCE NO. 3504 Bank St St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | white | single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) Dec 20/1891

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 35 | 0 | 20 21 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Milliner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Geo. W. Elton

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Catherine A. Geshen

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore, Md.

14 Informant Catherine A. Elton,

(Address) 3504 Bank St

1927 [illegible] M. D.

Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10/192 27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Veronal Poisoning-Overdose taken probably by mistake on Jan 7/27

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) John Mosser M. D.
(Coroner)

1/11/27 (Address) 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery Date of Burial June 13 1927

20 UNDERTAKER John Leeds ADDRESS 2nd & Aliceanna

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17781 E 17781

## CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. 26-37 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lewis Hayes

(a) RESIDENCE NO. 4331 Lombard st. St. Ward

(Usual place of abode) Unknown

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1881

7 AGE: 46 Years: 45 Months: Days: IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Louisiana

PARENTS

10 NAME OF FATHER Dallas Hayes

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Louisiana

12 MAIDEN NAME OF MOTHER ? Guidney

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Louisiana

14 Informant

(Address)

1927 C. HAMPSON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: January 8, 1927

17 I HEREBY CERTIFY, That I attended deceased from December 27 19 26 to January 8, 1927,

that I last saw him alive on January 8, 1927,

and that death occurred, on the date stated above, at 1.15 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

5 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) H. E. Latimer, M. D.

1-8-27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL Date of Burial 19: JAN 11 1927

20 UNDERTAKER: Commissioner Health ADDRESS

1927 Permit 2931

Spec.—12-9-25—A Co.—200 Bks.

(Doraetta Zopf)

HEALTH DEPARTMENT—CITY OF BALTIMORE

# E 17782

## CERTIFICATE OF DEATH.

# E 17782

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 528 N. Carrollton Ave Ward)

2-FULL NAME Doraetta Zopf

(a) RESIDENCE NO. 528 N. Carrollton Ave Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Adam Zopf

6 DATE OF BIRTH (month, day, and year) Dec 25, 1858

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 68 | 0 | 16 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Adam Zopf

(Address) 528 N. Carrollton Ave

15 Filed C. HAMPSON JONES, M. D.

1927 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 1927.

17

I HEREBY CERTIFY, That I attended deceased from June 2, 1926, to Jan 10, 1927, that I last saw h.. alive on Jan 10, 1927, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) few yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M Bowman Leech, M. D.

1/11, 1927 (Address) 626 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Date of Burial Jan. 13, 1927.

20 UNDERTAKER Mr. & Mrs. John W. Tempel & Son ADDRESS 601 N. Fayette

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

17783 — 14 E 17783

## CERTIFICATE OF DEATH

REGISTERED NO. 27-54

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Homewood Hosp. (ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Lillian A. Pierson

(a) RESIDENCE NO. South Ave. Mt. Washington WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of or) WIFE of Clarence N. Pierson

6 DATE OF BIRTH (month, day, and year) Sept 19. 1899

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 27 | 3 | 21 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Salt. Md.

PARENTS

10 NAME OF FATHER Washington B. Brawner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charles Co. Md.

12 MAIDEN NAME OF MOTHER Edith N. Lyons

13 BIRTHPLACE OF MOTHER (city or town) (State or country) A. A. Co. Md.

14 Informant Clarence N. Pierson

(Address) South ave. Mt. Washington

15 1 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-9 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan-6, 1927, to Jan-9, 1927,

that I last saw her alive on Jan. 9, 1927,

and that death occurred, on the date stated above, at 7. P. m.

The CAUSE OF DEATH* was as follows:

Surgical Shock following Obstetrical operation

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 1-6-27

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Path.

(Signed) K. C. Koerner, M. D.

1-9. 1927 (Address) 3600 York Rd. Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge

DATE OF BURIAL Jun. 12, 1927.

20 UNDERTAKER Wm. Mus. John H. Deufel & Son

ADDRESS 801 W. Fayette

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

17784

E 17784

## CERTIFICATE OF DEATH.

REGISTERED NO. 24-3331

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals (Fill in) St. _____ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edwin Clipper

(a) RESIDENCE NO. 127 W. Clement st. St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence Clipper

6 DATE OF BIRTH (month, day, and year) 1889

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 37 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER George Clipper

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Roser

13 BIRTHPLACE OF MOTHER (city or town) Balto.

(State or country) Maryland

14 Interment (Address) Hospital Records

15 JAN 1927 C. HAMPSON JONES, M. D. Per _____ Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 January 9, 1927

17 I HEREBY CERTIFY, That I attended deceased from January 5, 1927, to January 9, 1927, that I last saw h... in alive on January 9, 1927, and that death occurred, on the date stated above, at 6.00 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Tuberculous Enteritis Adm.

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Gross

(Signed) W. C. Mattens, M. D.

1-10-1927 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem. Date of Burial Jan 13 1927

20 UNDERTAKER C. Howard Evans ADDRESS 386 Fulton

Spec—12-23-21—E.B.R.S.—400 Bks. (Jentuson) ✓

E 17785 HEALTH DEPARTMENT—CITY OF BALTIMORE E 17785

CERTIFICATE OF DEATH. 100-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 1228 E Eager St 10-14 St., Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James H. Jentusen

(a) Residence No. 1228 E Eager St St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug 15/25

7-AGE. 1 yrs. 4 mos. 25 ds. 24

If LESS than 1 day, hrs. or mts.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Peter Jentusen

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER, Barbara Rock

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md

14-

(Informant) Peter Jentusen

(Address) 1228 E Eager St

15-

Filed 1 1927 C. HAMPSON JONES, M. D. Registrar.

Per

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 9 27

17- I HEREBY CERTIFY, That I attended deceased from about 12 1926 to 1927, that I last saw him alive on Jan 9 1927, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

1. Pneumonia

(Cause uncertain)

Bronchial Pneumonia

1 week (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? cl

(Signed) W. J. Rules M. D.

, 19 (Address) 1629 Riverside

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL 1 27 19 27

20-UNDERTAKER J. O. Rock — ADDRESS Baltimore

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17786 — CERTIFICATE OF DEATH. — E 17786

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home & Infirmary Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Joseph Spring

(a) RESIDENCE NO. St. Michaels, Md. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 21 dys. How long in U. S., if of foreign birth? yrs. mos. dys.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillie Spring

6 DATE OF BIRTH (month, day, and year) February 17, 1850

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 76 | 10 | 23 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired RR

(b) General nature of industry, business, or establishment in which employed (or employer) (Trainman)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) West Virginia

PARENTS

10 NAME OF FATHER Jacob Joseph Spring

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary A. Strean

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant Mrs. E. R. Ferrell

(Address) 2846 Woodbrook Ave.

15 Filed C. HAMPSON JONES, M. D. Registrar

JAN 1 1927 Per

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 January 10, 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 19 26, to Jan 10, 19 27, that I last saw h alive on Jan. 10, 19 27, and that death occurred, on the date stated above, at 11 40 A.m.

The CAUSE OF DEATH* was as follows:

Nephritis, chronic

(duration) yrs. mos. dys.

CONTRIBUTORY (Secondary) myocarditis, chronic

(duration) Unknown mos. dys.

18 Where was disease contracted

If not at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Chemistry

(Signed) George B Brief, M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Cumberland Allegany Co Md Jan 14 19 27

20 UNDERTAKER — ADDRESS

Pedtamer & Orr 1723 N Lafayette Ave

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17787

E 17787

## CERTIFICATE OF DEATH.

188-23

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hosp St. 16-23 Ward)

2-FULL NAME John Washington

(a) RESIDENCE NO. 536 N. Carey St. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: [illegible]

4 Color or Race: [illegible]

5 Single, Married, Widowed, or Divorced, (write the word): Single colored Negro

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 13, 1915

7 AGE Years 12 Months 1 Days 27 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Md.

PARENTS

10 NAME OF FATHER J. T. Washington

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Va.

12 MAIDEN NAME OF MOTHER Lucy Moody

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Va.

14 Informant Lucy Washington

(Address) 536 N. Carey St.

15 [illegible] 19 [illegible] RRH Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 10, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an [illegible] (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said [illegible] (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of pelvis (automobile accident)

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) _____

(duration) .....yrs. .....mos. .....ds.

(Signed) J. T. Kenney M. D. (Coroner)

Jan. 11, 1927 (Address) 210 E. Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem Date of Burial Jan 14 1927

20 UNDERTAKER Hunt Easton ADDRESS 116 Saratoga

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17788

## CERTIFICATE OF DEATH.

101 E 17788

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 427 N Fremont St., 4-26 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Jones

(a) RESIDENCE No. 427 N Fremont ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eva Jones

6 DATE OF BIRTH (month, day, and year) 1899

7 AGE — Years: 28 — Months — Days — If LESS than 1 day, ..... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER not known

11 BIRTHPLACE OF FATHER (city or town) (State or country): not known

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): not known

14 Informant: Eva Jones
(Address) 714 Baradan St

15 Filed 1 1927, 19 ..... HAMPSON JONES, M. D. Registrar
By ..... Clerk

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/11 1927

17 I HEREBY CERTIFY, That I attended deceased from 1/6/27, 19..... to 1/11, 1927.
that I last saw him alive on 1/11/27, 19.....
and that death occurred, on the date stated above, at 11:30 A m.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
..... (duration) — yrs. — mos 6 ds.
CONTRIBUTORY (Secondary) Cardiac Hypertrophy
..... (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Gustav Ohlman, M. D.
, 19 (Address) 656 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL Jan 11 27

20 UNDERTAKER: Dan Easton — ADDRESS 96 Eutaw

Spec.—1-12-23—M&T—500 Blks.

E 17789 HEALTH DEPARTMENT—CITY OF BALTIMORE E 17789

CERTIFICATE OF DEATH. 51

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 864 Rebecca St. 18-26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie Zenetor Snowden

(a) RESIDENCE NO. 864 Rebecca St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE: 56 (Years | Months | Days | If LESS than 1 day, hrs. or min.)

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Walter Snowden

(Address) 538 Redwood St

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

By

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 12 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 5, 1927, to Jan 9, 1927

that I last saw her alive on Jan 9, 1927

and that death occurred, on the date stated above, at 9:05 P. m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry Glassman M. D.

Jan 19 27 (Address) 26 S. Wolfe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: Jan 14 1927

20 UNDERTAKER: Hunt Carter

ADDRESS 946 Gay St

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17790

5496

## CERTIFICATE OF DEATH.

90 E 17790

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 1122 McCulloh St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. J. Hooper

(a) RESIDENCE NO. 1122 McCulloh St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male | 4 Color or Race: colored | 5 Single, Married, Widowed, or Divorced, (write the word): widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) about 1872

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 55 | | | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Janitor
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer Dunlop Apts.

9 BIRTHPLACE (city or town)_____
(State or country) Md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)_____
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)_____
(State or country)

14 Informant Geo. Conrad
(Address) Baltimore, Md.

JAN 1 1927 C. HAMPSON JONES, M. D. Registrar
Per A.R.H.

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 1, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic heart disease

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) senile debility

(duration) yrs. mos. ds.

(Signed) J. T. Yarnall, M. D.
(Coroner)

1/10, 1927 (Address) 1802 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs. mos. ds. In the state yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial 19 |
|---|---|
| Laurel Cem. | Jan 11/27 |
| 20 UNDERTAKER Wm. Taylor & Sons | ADDRESS Balto |

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17791

## CERTIFICATE OF DEATH.

129 E 17791

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 434 N. Fremont ST. 18-26 WARD)

2-FULL NAME Elizabeth Leadman

(a) RESIDENCE NO. 434 N. Fremont ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Colord | Married |

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1884

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs or ... min |
|---|---|---|---|---|
| | 43 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Emmels

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Brewer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West River

14 Informant William Leadman
(Address) 434 N. Fremont Ave

15 Filed ..... 19 ..... Registrar

1927 RKH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 9 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1926, to Jan. 9, 1927, that I last saw her alive on Jan. 8, 1927, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Apoplexy 7

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis & Complications Diseases (duration) ... yrs. 8 mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? Posture

(Signed) G. H. W. Kennard, M. D.

1-10, 1927 (Address) 708 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Cambridge, Md | Jan 12 27 |

20 UNDERTAKER Wm. T. Easton — ADDRESS 916 Pine

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17792

## CERTIFICATE OF DEATH.

101-001

E 17792

1-PLACE OF DEATH

City of BALTIMORE: (No. 516 S. Sharp St. 22-30 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen R. Skidmore.

(a) RESIDENCE NO. 516 S. Sharp St. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred __ yrs. 5 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female. | White. | Single. |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) July 24, 1926

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 0 | 5 | 18 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER William Skidmore.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia.

12 MAIDEN NAME OF MOTHER Rllen Gray.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia.

14 Informant William Skidmore. (father)

(Address) 516 S. Sharp St.

15 1927 C. HAMPSON JONES, M. D. Registrar

Per Rkk

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 11, 1927. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Fennard M. D. (Coroner)

1/11 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary Hampden Lee Date of Burial: Jan 12 1927

20 UNDERTAKER: Wm Cook ADDRESS: 502 E north ave

Cor.—12-9-25—A Co.—200 Bks.

E 17793

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

179

E 17793

1-PLACE OF DEATH

REGISTERED NO._____

City of BALTIMORE: (No. South Baltimore General Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laura F. Sykes.

(a) RESIDENCE NO. 9 E. Williamson St. St. 23-31 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 5 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| ~~Female~~. | White. | Married |

5a If married, ~~XXXXXXXXXXXXXX~~ ~~XXXXXXXXXX~~ (or) WIFE of Alexander Konig.

6 DATE OF BIRTH (month, day, and year) August 8, 1860

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 66 | 5 | 8 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Sykes.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Virginia Cannon.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore, Md.

14 Informant Edward L. Konig. (son)

(Address) 11 E. Williamson St.

15 Filed 1 1927 19 C. HAMPSON JONES, M. D.

Registrar

Per Rkw

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 11, 1927. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns about the chest and body while lighting stove. Accidental Death. Traumatic Pneumonia.

over

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signature) Otto M. Leinhardt M. D.

1/11 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? 9 E. Williamson St. December 19, 1926.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery Date of Burial Jan 14 1927

20 UNDERTAKER Wm Cook ADDRESS 502 E north ave

Spec.—1-10-21—M&T—1500 Bks.

E 17794

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 17794

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1329 N. Mount St. 5-21 WARD)

2-FULL NAME Samuel Brown

(a) RESIDENCE NO. 1329 N. Mount ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hagar Brown

6 DATE OF BIRTH (month, day, and year): 1865

7 AGE: Years 62 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Day laborer

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country): West River, Anne Arundel Co., Maryland

10 NAME OF FATHER: Thomas Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): West River, Anne Arundel Co., Maryland

12 MAIDEN NAME OF MOTHER: Anne Parker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): West River, Anne Arundel Co., Md.

14 Informant (Address): Sarah Brown, 1329 N. Mount St

15 1 1927 Reg. C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1-8-1927

17 I HEREBY CERTIFY, That I attended deceased from Dec. 12. 1926. to Jan 8. 1927.

that I last saw h alive on Jan 7. 1927.

and that death occurred, on the date stated above, at 11.30 a. m.

The CAUSE OF DEATH* was as follows:

C. myocarditis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? physical signs & symptoms

(Signed) John G. S. Lampe, M. D.

, 19 (Address) 1405 N. Mount

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: West River Md.

DATE OF BURIAL: Jan 12 1927

20 UNDERTAKER: Mrs James H. Dennis per T. E. Kelson

ADDRESS: 1303 Pennsylvania Ave

spec.—1-12-23—M&T—300 Blks.

E 17795 HEALTH DEPARTMENT—CITY OF BALTIMORE E 17795

CERTIFICATE OF DEATH.

REGISTERED NO. 12-57 1001

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) West Baltimore Gen St. Hospital (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Ida Talbot.

(a) RESIDENCE NO. 2011 Woodberry Ave (St.) (WARD)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Herbert Talbott

6 DATE OF BIRTH (month, day, and year) April 30 1869

7 AGE Years 57 Months 8 Days 10 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Stophel Pressgar

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Buel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) West Baltimore Gen Hospital

Filed 1 1927 C. HAMPSON JONES, M. D. Registrar

By A.B.W.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/9 1927

17 I HEREBY CERTIFY, That I attended deceased from 12/7, 1926, to 1/9, 1927, that I last saw h[illegible] alive on 1/9, 1927, and that death occurred, on the date stated above, at 12 00 m.

The CAUSE OF DEATH* was as follows:

Cellulitis of Leg.

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Arnold L Jensen, M. D.

1/7, 1927 (Address) West Baltimore Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Forest Cemetery, Balto. Co. DATE OF BURIAL Jan. 12 1927

20 UNDERTAKER E. LeRoy Stiffler ADDRESS 1057 E North Ave

Spec.—6-9-19—H. P. Co.—1000 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

17796

## CERTIFICATE OF DEATH.

1927 E 17796

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 916 Park av ST.) 11-24 (WARD)

2-FULL NAME Howard Enos

(a) RESIDENCE. NO. 916 Park av ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louisa Enos

6 DATE OF BIRTH (month, day, and year): 1884

7 AGE: 42 (Years | Months | Days | If LESS than 1 day, hrs. or min.)

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Calvert Co Md

PARENTS

10 NAME OF FATHER: Daniel Enos

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Eliza Dumsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Louisa Enos 916 Park av

15 Filed 1 1927

C. HAMPSON JONES, M. D. Registrar

Per ARM

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/8/27

17 I HEREBY CERTIFY, That I attended deceased from Dec 9. 1926. to Jan 8. 1927.

that I last saw h[illegible] alive on Jan 7. 1927.

and that death occurred, on the date stated above, at 7-30 P m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary): Arterial Sclerosis

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? 1/2/1

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Albuminuria etc

(Signed) W. H. Peagel M. D.

(Address) 2105 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sharp St Cem Calvert Co Md

DATE OF BURIAL: Jan 12 1927

20 UNDERTAKER: Samuel J Hemsley

ADDRESS 578 W Baltimore

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17797

129

E 17797

## CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 632 Sterling St St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alexander Kelly

(a) RESIDENCE NO. 632 Sterling St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | col | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: uhknown

6 DATE OF BIRTH (month, day, and year): 1884

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 43 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Stevedore

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Md

PARENTS

10 NAME OF FATHER: Levi Kelly

11 BIRTHPLACE OF FATHER (city or town)

(State or country): MD

12 MAIDEN NAME OF MOTHER: Harriett Brown

13 BIRTHPLACE OF MOTHER (city or town): Md

(State or country)

14 Informant: Florence Jackson (niece)

(Address): 609 N. Bond St

15 Filed ... 19 ... C. HAMPSON JONES, M. D. Registrar

JAN 12 1927 Per [illegible]

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 9/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Chr. Nephritis with Cardiac Failure.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

(Signed) J. H. Price M.D. M. D.

(Coroner)

1/11/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion cemty Date of Burial: Jan 12, 19 27

20 UNDERTAKER: Edward Bryan ADDRESS 1691 Orleans St

Spec.—7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17798

## CERTIFICATE OF DEATH

E 17798

REGISTERED NO.

1-PLACE OF DEATH St. Agnes Hospital

City of BALTIMORE: (No. 416 N. Camden St., (Ward) 27-30

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Luiza

(a) RESIDENCE NO. 415 N. Camden St. Ward At Sea (Non Res)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs 3 mos. ds. How long in U. S. if of foreign birth? 30 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosa Luiza

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE: Years 45 Months Days IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work No

(b) General nature of industry, business, or establishment in which employed (or employer) Off

(c) Name of employer

9 BIRTHPLACE (city or town) LETHVANIA

(State or country)

PARENTS

10 NAME OF FATHER John Luiza

11 BIRTHPLACE OF FATHER (City or town)

(State or country) LETHVANIA

12 MAIDEN NAME OF MOTHER Atose KIZELUTE

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Lethvania

14 Informant Wife Rosa — 415 N Camden

(Address)

15 Filed Jan 20 1927 WILLIAM H. JONES M. D. Registrar

Per

JAN 21 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1927, to Jan 10, 1927

that I last saw h/M alive on Jan 10, 1927.

and that death occurred, on the date stated above, at 12 55 P.M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

and Pulmonary Oedema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardio-renal disease

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Theron Hunter M. D.

1/10. 1927 (Address) St. Agnes' Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — Date of Burial: Jan. 12. 1927

20 UNDERTAKER: John Grebliauckas — ADDRESS: 423 S. Paca St

Alex Panasuk

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 17799

REGISTERED NO. E 17799

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 928 W Lexington ST.) 18-16 100-001 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alx. PANASUK

(a) RESIDENCE NO. 928 W Lexington ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 7. 1926

| 7 AGE — Years | Months | Days | If LESS than 1 day, hrs or ... min. |
|---|---|---|---|
| | 2 | 3 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work No.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Andrus Panasuk

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russian

12 MAIDEN NAME OF MOTHER Anna Babinka

13 BIRTHPLACE OF MOTHER (city or town) Russian
(State or country)

14 Informant A. Panasuk
(Address) 928 W Lexington Street

15 Filed JAN 12 1927 Registrar HARRY JONES, M. D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1927, to Jan 10, 1927.

That I last saw him alive on Jan 10, 1927

and that death occurred, on the date stated above, at 11.10 A m

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs & Symptoms

(Signed) Edgar B Tindemald, M. D.

Jan 11, 1927 (Address) 1616 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Russian Indepedet — DATE OF BURIAL: Jan. 12. 1927

20 UNDERTAKER: John Grebliauckas — ADDRESS: F. G. 423 S Paca St

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17800

## CERTIFICATE OF DEATH.

185 E 17800

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Terrace St., 20-70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Bissett

(a) RESIDENCE NO. 3141 Frederick Ave. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 14, 1861

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 65 | 2 | 27 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer): 088

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) Md.

PARENTS

10 NAME OF FATHER Thos. Bissett

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Emory

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Md.

14 Informant Chas. E. Bissett

(Address) 3141 Frederick Ave

Filed NOV 2 1927 19 C. HAMPSON JONES, M. D. Registrar

Per RRL

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 14 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Fem. Transverse (Compound Infected)

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Cardiac Decomp

(duration) .....yrs. .....mos. .....ds.

(Signed) C. H. Hampson, M. D.

(Coroner)

Oct. 15, 19 27 (Address) 2 W Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.,.....ds. In the State.....yrs.....mos.,.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

Date of Burial: 10/14 1927

20 UNDERTAKER: Robert Brookerson

ADDRESS: Calhoun & Lafayette

Spec.—1-12-23—M&T—500 Bks.

9E 17801 HEALTH DEPARTMENT—CITY OF BALTIMORE 101-09 E 17801

# CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL REGISTERED NO.

CITY OF BALTIMORE: (No. 7-9 ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joel Walter Jeffers -

(a) RESIDENCE NO. North Pr. Rd. Sparrows WARD Pr-Md -
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word)

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6b DATE OF BIRTH (month, day, and year)

7 AGE — Years | Months: 3 wks | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md -

PARENTS

10 NAME OF FATHER: Geo. Jeffers -

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER: Hazel Jeffers

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address): Records - JOHNS HOPKINS HOSPITAL

Filed DEC 12 1927, 19 C. HAMPSON JONES, M. D. Registrar

For R/P

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 9 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 14, 1926, to Jan 9, 1927, that I last saw him alive on Jan 9, 1927 and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Emphysema (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? X-ray - Thoracentesis

(Signed) Geo. C. Cornwall M. D.

, 19 Address Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS JOHNS HOPKINS HOSPITAL

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

167-001

E 17802

## CERTIFICATE OF DEATH.

71-29

E 17802

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 810 N. Wanticoke St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry B. Seidel

(a) RESIDENCE NO. 810 N. Wanticoke St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 20th 1861

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 65 | 7 | 21 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist Helper

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Hindeberg

(State or country) Germany

PARENTS

10 NAME OF FATHER John G. Seidel

11 BIRTHPLACE OF FATHER (city or town) Saxon

(State or country) Germany

12 MAIDEN NAME OF MOTHER Henrietta Neubauer

13 BIRTHPLACE OF MOTHER (city or town) Saxon

(State or country) Germany

14 Informant Conrad Seidel

(Address) 1 Hamilton ave. Roseburg

Filed JAN 12 1927

C. HAMPSON JONES, M. D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 10 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest or inquiry.) thereon and from the evidence obtained by said Inquest, find that said deceased came to death (Inquest or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Monoxide Gas Poisoning

Suicide — Found dead Inhaling Gas from Stove (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

Jan 12, 1927 (Signed) Thos. B. Norton M. D. (Coroner)

(Address) 1 E. Lexington St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Jerusalem Lutheran Cemetery Date of Burial Jan. 13 1927

20 UNDERTAKER Fred'k Eschmann Sons ADDRESS Fulton ave

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 17803 — REGISTERED NO. E 17803

1-PLACE OF DEATH

City of BALTIMORE: (No. 2863 W Lanvale St. 25-32 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude L Goldhammer

(a) RESIDENCE NO. 635 Indiana Ave. East St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| F | W | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 4, 1926

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 11 | 10 | 28 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer

9 BIRTHPLACE (city or town) ...
(State or country) Balto Md

PARENTS

10 NAME OF FATHER Thos L Goldhammer

11 BIRTHPLACE OF FATHER (City or town) ...
(State or country) Balto Md

12 MAIDEN NAME OF MOTHER Susie Talbott

13 BIRTHPLACE OF MOTHER (city or town) ...
(State or country) Balto Md

14 Informant Thos L Goldhammer
(Address) 635 Indiana Ave East St

15 Filed JAN 12 1927 19 C. HARRISON JONES, M. D. Registrar

Per RAL

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 12 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 6, 1927, to Jan 12, 1927.

that I last saw her alive on Jan 12, 1927.

and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Mastoiditis

(duration) yrs. mos. 4 da.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 7 da.

18 Where was disease contracted

if not at place of death? ...

Did an operation precede death? yes Date of Jan 9

Was there an autopsy? no

What test confirmed diagnosis? Clinical Course.

(Signed) Jos L Mierlen, M. D.

Jan 12 1927 (Address) 111 W Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — Date of Burial Jan 14 1927

20 UNDERTAKER W M Cook — ADDRESS 1032 E Baltimore

# NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

Cor.—12-9—A Co.—200 Bks.

E 1804

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17804

## CERTIFICATE OF DEATH.

Nov 11-24 1925

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Maryland Avenue St. Paul Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick W. Lubba

(a) RESIDENCE NO. Swanson Point Rd St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ____ mos. / ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| m | w. | married |

5a If married, widowed, or ~~divorced~~ HUSBAND of (or WIFE of) Mary E. Lubba.

6 DATE OF BIRTH (month, day, and year) Feb 23, 1865

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 61 | 10 | 18 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shipfitter

(b) General nature of industry, business, or establishment in which employed (or employer) Ship

(c) Name of employer Bethlehem Steel Co

9 BIRTHPLACE (city or town) _____

(State or country) Germany

PARENTS

10 NAME OF FATHER Henry Lubba

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Germany

14 Informant Mrs. E. A. Wilson

(Address) 3 Kirkwood Pl

Filed JAN 12 1926 C. HAMPSON JONES, M. D. Registrar

By _____

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11 1925

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an _____ (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said _____ (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Shock & burns, burns of body accidental. (Fractured skull)

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) _____ (duration) ____ yrs. ____ mos. ____ ds.

(Signed) _____ M. D. (Coroner)

Jan 12, 1926 (Address) 2807 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Michaels Md Date of Burial Jan 17 1926

ADDRESS _____

UNDERTAKER Hunter Bros 5026 Eastern Ave

OF DEATH in plain terms, so that very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

101-001

E 17805 — REGISTERED NO. E 17805

1-PLACE OF DEATH

City of BALTIMORE: (No. 508 Aisquith St St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cornelius Curtis

(a) RESIDENCE NO. 508 Aisquith St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | col | widower |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): May-----

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| about, | 42 | 5 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Waiter

(b) General nature of industry, business, or establishment in which employed (or employer): Rennert Hotel

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Cornelius Curtis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Margaret Estell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Alice Vodery

(Address): 1533 McElderry St

15 Filed JAN 12 1927 H. HARRY JONES, M. D. Registrar

Per

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 Jan 9/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably (Lobar) Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. H. Weiss M. D.

(Coroner)

1/12/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Calvary — Date of Burial: 1/12/27

20 UNDERTAKER: Mrs. R. G. Elliott — ADDRESS: 1725 Eastland

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17806

## CERTIFICATE OF DEATH.

E 17806

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. West Balto. Gen. Hosp. St., 20-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John A. Wright

(a) RESIDENCE NO. 1806 N Fayette St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | widower |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 8 1854

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 65 | 1 | 3 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Secret Service (retired)
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Government

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Alexander Wright

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Esther Hall

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant
(Address)

15 Filed DEC 2 1927 19 C. HARRISON JONES, M. D.
Per Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 11 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as followst

Bronchial Pneumonia

(duration) 7 days.

CONTRIBUTORY (Secondary) Contusion of left shoulder

(duration) 1 year. yrs. mos. ds.

(Signed) H. Tolliver Lee Coroner M. D.

Jan 12, 1927 (Address) 785 N Eden St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Date of Burial Jan 13 1927

20 UNDERTAKER George J Smith ADDRESS 1532 Hollins St

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17807

## CERTIFICATE OF DEATH.

1-20 114

E 17807

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md General Hospital St. WARD)

2-FULL NAME Martin Yonce

(a) RESIDENCE No. St. Vincents Orphan Asylum St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 30, 1924

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 2 | | 10 11 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John J. Yonce

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records (Address)

15 Filed JAN 12 1927 C. HAMPSON JONES, M. D. Registrar Per R.H.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-10 1927

17 I HEREBY CERTIFY, That I attended deceased from 1-8 —, 1927, to 1-10, 1927.

that I last saw him alive on 1-10, 1927.

and that death occurred, on the date stated above, at 6.00 m.

The CAUSE OF DEATH* was as follows:

Gastro - Enteritis

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) John A Donaghue M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. DATE OF BURIAL 1/12 1927

20 UNDERTAKER George A Tarby ADDRESS Fulton & Fayette

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17808

## CERTIFICATE OF DEATH.

17-24 90

E 17808

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. ____ St., 17 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME William Tillman

(a) RESIDENCE NO. 507 Oxford St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Negro | married |

3a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1879

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 48 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Tillman

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant

(Address) Records

Filed JAN 12 1927 C. HAMPSON JONES, M. D. Registrar

By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 10 1927

17 I HEREBY CERTIFY, That I attended deceased from January 6, 1927, to January 10, 1927, that I last saw him alive on January 10, 1927, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Emphysema, Chronic Myocarditis & Insufficiency, Arterial Sclerosis Aortic Insufficiency.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? General & Laboratory

(Signed) D. D. Cooper Smith M. D.

Jan 12 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Date of Burial Jan 19 27

20 UNDERTAKER Daniel Easton ADDRESS 69 ave

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17809

## CERTIFICATE OF DEATH.

8-17 129

REGISTERED NO. E 17809

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2010 E. North Avenue ST., 8 WARD)

2-FULL NAME Thomas J. Keough

(a) RESIDENCE No. 2010 E. North Avenue ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

6a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Emma Nixon

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| About | 80 | -- | -- | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pilot

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Newfoundland

PARENTS

10 NAME OF FATHER Nicholas Keough

11 BIRTHPLACE OF FATHER (city or town) (State or country) Newfoundland

12 MAIDEN NAME OF MOTHER Ellen Fardy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Newfoundland

14 Informant Mrs. Emma N. Keough
(Address) 2010 E. North Avenue

15 Filed 1-12-1927 C. HAMPSON JONES, M. D.
Registrar
Per RR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 10 1927.

17 I HEREBY CERTIFY, That I attended deceased from September 18 1926 to January 10 1927.

that I last saw h[illegible] alive January 10. 1927.

and that death occurred, on the date stated above, at 4.10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
and Arterial Hypertension.
Mitral Insufficiency
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac dilatation
(duration) yrs. mos. 1. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination and urinalysis.

(Signed) Albert Abrahams M. D.

1/11. 1927 (Address) 2027 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL 1/13 1927

20 UNDERTAKER Henry C. Dorsey & Sons

ADDRESS [illegible]

Spec. -7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17810 — 129 E 17810

## CERTIFICATE OF DEATH

1-PLACE OF DEATH — REGISTERED NO. 1-2

City of BALTIMORE: (No. 604 S. Potomac St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bridget Green

(a) RESIDENCE NO. 604 S. Potomac St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S. if of foreign birth 52 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: Joseph Green

6 DATE OF BIRTH (month, day, and year): Sept 29 1857

7 AGE: Years 69 Months 3 Days 11 IF LESS than 1 day hrs. or min..

70

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Joseph Devany

11 BIRTHPLACE OF FATHER (City or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Nora Hanlon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Mrs. Green 604 S. Potomac St

2 1927 C. HAMPSON JONES, M. D. Registrar

Per A.R.H.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: Jan. 10. 27

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1926, to Jan 10, 1927, that I last saw h[er] alive on Jan 10, 1927, and that death occurred, on the date stated above, at 7:10 P.m.

The CAUSE OF DEATH* was as follows:

chr Interstitial Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & Uremia (duration) yrs. mos. 3 ds.

18 Where was disease contracted: —

If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Sat. & Phys.

(Signed) J. Joseph Lanbey, M. D.

. 19 (Address) 720 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenbatchel Bur

Date of Burial: 1/13/27

20 UNDERTAKER: J. J. Doran

ADDRESS: E Baltimore

Very Important: See instructions on reverse side.

Spec.—12-9-25—A Co.—200 Pks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17811 38 E 17811

E 17811

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. St., 1927 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Warren Keating

(a) RESIDENCE NO. 322 Bond St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Negro | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1880

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 47 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Phila. Delphina

(State or country) Penna

PARENTS

10 NAME OF FATHER Charles Keating

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Balto City Records Hospital

(Address)

15 Filed C. HAMPSON JONES, M. D. Registrar

2 1927 Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 10 1927

17

I HEREBY CERTIFY, That I attended deceased from December 1, 1926, to January 10, 1927, that I last saw h[illegible] alive on January 10 1927, and that death occurred, on the date stated above, at 9 15 P m.

The CAUSE OF DEATH* was as follows:

Aneurysm Aortic Arch

Chronic Myocarditis ? Arteriosclerosis

(duration) yrs. ? mos. ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? General & Laboratory

(Signed) R Harper Smith, M. D.

Jan 12 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Cemetery Date of Burial Jan 12 1927

20 UNDERTAKER Joseph A Lively ADDRESS 409 N. Mount St

Spec.—1-10-21—M&T—1500 Bks.

17812

# HEALTH DEPARTMENT—CITY OF BALTIMORE

17812

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3008 Belmont Ave ST. 16-67 WARD) 100-201

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Ashby Davis

(a) RESIDENCE NO. 3008 Belmont Ave ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W.

5 ~~Single~~, Married, ~~Widowed, or Divorced~~ (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Melissa L Davis

6 DATE OF BIRTH (month, day, and year): Dec 11 - 1872

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or ... min. |
|---|---|---|---|---|
| | 54 | 1 | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Pullman Conductor

(b) General nature of industry, business, or establishment in which employed (or employer): 93

(c) Name of employer: Pullman Palace Car Co.

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Edgar O Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Richmond Va

12 MAIDEN NAME OF MOTHER: Mary E Hamilton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Mrs Melissa L Davis
(Address) 3008 Belmont Ave

Filed JAN 2 1927 C. HAMPSON JONES, M. D. Registrar

Per R H H

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 11th 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 6th, 1927, to Jan 11th, 1927, that I last saw h living alive on Jan 11th, 1927, and that death occurred, on the date stated above, at 11.45 A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

CONTRIBUTORY (Secondary) Influenza (duration) yrs. mos. 6 ds.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wilmer Eagleton, M. D.

(Address) 1501 E Eager St

Jan 12th, 1927

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: Jan 14th 1927

20 UNDERTAKER: Pickard & Poe

ADDRESS: 1723 Eutaw

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17813

E 17813

## CERTIFICATE OF DEATH.

REGISTERED NO. 124

1-PLACE OF DEATH Maryland General Hospital

CITY OF BALTIMORE: (No. 18-29 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Ada E. Slacum

(a) RESIDENCE NO. 929 Hollins ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. 6 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William J Slacum

6 DATE OF BIRTH (month, day, and year) Aug. 2, 1885

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 41 years | 5 | 8 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Manchester Co Md

PARENTS

10 NAME OF FATHER Samuel Mathews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Manchester Co Md

12 MAIDEN NAME OF MOTHER Alice Evans

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Manchester Co Md

14 Informant Mayer Evans

(Address)

15 JAN 2 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 9 1927 to Jan 10 1927.

that I last saw h[illegible] alive on Jan 10 1927.

and that death occurred, on the date stated above, at 8.25 P m.

The CAUSE OF DEATH* was as follows:

Obstruction Jaundice

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

Toxemia (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Hampson Jones M. D.

1/10, 1927 (Address) 1 W Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL Jan. 13 1927

20 UNDERTAKER Joseph B Cole

ADDRESS 1053 W Balto St

Spec.—1-12-23—M&T—500 Blks.

E 17814

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17814

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. 33rd and Calvert ST. 11-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Samuel H. T. Hayes.

(a) RESIDENCE NO. The Cecil Apts. Eutaw Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | Married |

a If married, widowed, or divorced HUSBAND of (or) WIFE of Grace Parsons Hayes

DATE OF BIRTH (month, day, and year) Feb. 27, 1867

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 59 | 10 | 16 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chemist and Bacteriologist

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Oxford Maine

PARENTS

10 NAME OF FATHER Cyrus Hayes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maine

12 MAIDEN NAME OF MOTHER Elizabeth Jenkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mass.

14 Informant (Address) Union Memorial Hospital Rec. 33rd & Calvert Streets

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1927, to Jan 11, 1927, that I last saw h[illegible] alive on Jan 11, 1927, and that death occurred, on the date stated above, at 10.30 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) 3-4 [illegible] mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. L. Hannah, M. D.

Jan 11 1927 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery

DATE OF BURIAL: Jan. 14 1927

20 UNDERTAKER: Isaac Block

ADDRESS: 1003 W. Baltimore

ec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

17815 | CERTIFICATE OF DEATH. | 17815

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 112 Sipple Avenue ST., 26-41 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella, Rebecca Cathcart

(a) RESIDENCE No. 112 Sipple Avenue ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widowed |

a If married, widowed, or divorced HUSBAND of (or) WIFE of James Edward Cathcart

DATE OF BIRTH (month, day, and year) Nov. 24 1859

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 67 | 1 | 17 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER William Dean

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Laura S. Keilholtz

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant William Edward Cathcart (Address) 112 Sipple Avenue

15 Filed 2 1927 . 19 C. HAMPSON JONES, M. Registrar

For

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 10 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug. 15 , 1926 , to Jan 10, , 1927 .

that I last saw her alive on Jan. 10, , 1927

and that death occurred, on the date stated above, at 5.42 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Ovary.

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) General Arteriosclerosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Sept 18/26

Was there an autopsy? no.

What test confirmed diagnosis? Physical Ex

(Signed) J. M. Lamperson, M. D.

Jan. 11, 1927 (Address) 826 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Loudon Park Cemetery | Jan. 13 1927 |

20 UNDERTAKER Harold Cook ADDRESS 1003 W Balto St

E 17816

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 17816

1-PLACE OF DEATH

City of BALTIMORE: (No. 1420 E Pratt St. 3-4 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles London

(Residence in Baltimore: No. 1420 E. Pratt St.; yrs. mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

| 3-SEX. | 4-COLOR OR RACE. | 5-Single, Married, Widowed, or Divorced. (Write the word.) |
|---|---|---|
| Male | Colored | |

6-DATE OF BIRTH.

..... (Month) 1..... (Day) ..... (Year)

| 7-AGE. | If LESS than 1 day, |
|---|---|
| 40 yrs. mos. ds. | hrs. or min.? |

8-OCCUPATION.
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... 067

9-BIRTHPLACE. (State or Country).

PARENTS.

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER. (State or Country).

12-MAIDEN NAME OF MOTHER.

13-BIRTHPLACE OF MOTHER. (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- JAN 2 1927 C. HAMPSON JONES, M. D. Registrar.
Per ..... 192.....

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 4 (Day) 192[illegible] (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Alcoholism

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) 3 yrs. ..... mos. 1 ds.

(Signed) Jan 8/26 G. E. Hodes M. D.
(Coroner.)
192... (Address) 143 W. Bray

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

| 19-PLACE OF BURIAL OR REMOVAL. | DATE OF BURIAL. |
|---|---|
| JOHNS HOPKINS HOSPITAL | ..... 19.. |

| 20-UNDERTAKER. | ADDRESS |
|---|---|
| Commissioner Health | JAN 12 1927 |

THE MORGUE

Cor.—12-9-25—A Co.—200 Bks.

Martha

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 17817

E 17817

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin & Hanover St., Ward) Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jessie Murphy

(a) RESIDENCE NO. 113 N. Paca St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Unknown |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| about | 55 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Franklin Sq. Hospital

(Address) Balto

1927 C. HAMPSON JONES, M. D.

By Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest

.....find that said deceased came to h.....death by

(autopsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho - Pneumonia

(duration) 2 days Hospital

CONTRIBUTORY (Secondary) Uraemia

(duration) Unknown

(Signed) Thos. [illegible] Hartman M. D.

(Coroner)

Jan 11 1927 (Address) Curtis Bay.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (If reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

JOHNS HOPKINS HOSPITAL JAN 13 1927

20 UNDERTAKER — ADDRESS

Commissioner Health

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17818

1001

10 E 17818

## CERTIFICATE OF DEATH.

1 PLACE OF DEATH University Hospital

CITY OF BALTIMORE (No. Lombard & Green Sts. 22-30 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Anna E. Grove

(Residence in Baltimore: No. 680 Washington Bloulevard St.; yrs., 2½ mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

| 3-SEX. | 4-COLOR OR RACE, | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) |
|---|---|---|
| Female | White | Single |

6-DATE OF BIRTH, June (Month) 26 (Day), 1923 (Year).

7-AGE, 3 yrs. 6 mos. 17 ds. If LESS than 1 day, ....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Knoxville, Maryland

PARENTS.

10-NAME OF FATHER, George T. Grove

11-BIRTHPLACE OF FATHER (State or Country), Weaverton, Washington Co., Md.

12-MAIDEN NAME OF MOTHER Minnie Price

13-BIRTHPLACE OF MOTHER (State or Country), Sharpsburg, Washington co., Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Minnie Price

(Address) 680 Washington Blvd

15- Filed ....., 1927 C. HAMPSON JONES, M. D. Registrar.

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 12 (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Laryngeal Obstruction

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Manuel S. Baker M. D. (Coroner.)

Jan. 12, 1927 (Address) 332 S. Patterson Pk. Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

| 19-PLACE OF BURIAL OR REMOVAL, | DATE OF BURIAL, |
|---|---|
| Knoxville, Wash. Co., Md. | Jan. 13, 1927 |

| 20-UNDERTAKER | ADDRESS |
|---|---|
| J. A. Block | 1003 W. Balto. St. |

Spec.—1-10-21—M&T—1500 Bks.

E 17819

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17819

## CERTIFICATE OF DEATH.

161-081

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3122 Fait Ave ST. 1-1 WARD)

2-FULL NAME Robert Schuck

(a) RESIDENCE NO. 3122 Fait Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 28, 1926

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | | 2 | 14 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. M. Schuck

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Regina Marburger

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Wm. M. Schuck (Address) 3122 Fait Ave

15 Filed JAN 12 1927 C. HAMPSON JONES, M. D. Registrar Per CRH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 5 1926 to Jan 11 1927 that I last saw h[illegible] alive on Jan 10 1927 and that death occurred, on the date stated above, at 9.15 a m.

The CAUSE OF DEATH* was as follows:

Marasmus

(duration) yrs. 2 mos + ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? those of Marasmus

(Signed) Walter C Bacon M. D.

1/11. 1927 (Address) 100 E 20th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Pauls Cemetery — DATE OF BURIAL: Jan 13 1927

20 UNDERTAKER: Henry Sander & Sons Inc — ADDRESS: 1710 Fleet St.

Spec.—1-12-23—M&T—500 Bks.

E 17820

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17820

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3903 (ST.) Gwynn Oak Ave (WARD) 28-6

REGISTERED NO. 157

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sariah Jane Keyes

a) RESIDENCE NO. 3903 Gwynn Oak Ave ST., WARD Residence

(Usual place of abode)

(If non-resident give city or town and State)

gth of residence in city or town where death occurred 55 yrs. 5 mos. 0 ds. How long in U. S., if of foreign birth? 55 yrs. 5 mos. 0 ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: James Clifton Keyes

6 DATE OF BIRTH (month, day, and year): Aug-11-1871

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 55 | 5 | 0 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Daniel Kraft

11 BIRTHPLACE OF FATHER (city or town) (State or country): Carroll Co. Maryland

12 MAIDEN NAME OF MOTHER: Mary C. Ebaugh

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Carroll Co. Maryland

14 Informant: J. Clifton Keyes (husband)

(Address): 3903 Gwynn Oak Ave

15 FILED: Jan 12 1927 C. HAMPSON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 11-1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 15-1925 to Jan. 11-1927.

that I last saw her alive on Jan. 11-1927.

and that death occurred, on the date stated above, at 10:15 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

Cerebral Hemorrhage about 3 yrs ago.

Diabetic Coma.

(duration) 12 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Urine, Lab. Test

(Signed) J. Ward Bauer, M. D.

(Address) 2125 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery

DATE OF BURIAL: Jan 14 1927.

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS: 108 W. NORTH AVE.

Spec.—1-10-21—M&T—1500 Blks.

E 17821

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17821

## CERTIFICATE OF DEATH.

15-60 12

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hospital St., Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna E. Duvall

(a) RESIDENCE No. 1644 Maryland Ave. St., Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 75 yrs. 7 mos. 12 ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: None

6 DATE OF BIRTH (month, day, and year): May-30-1851

7 AGE — Years: 75 Months: 7 Days: 11. If LESS than 1 day, hrs or min.: 12

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) Anne Arundel County (State or country) Maryland

PARENTS

10 NAME OF FATHER Dr. Warren H. Duvall

11 BIRTHPLACE OF FATHER (city or town) A.A. County (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary E. Kent

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Dr. Henry C. Harrison (brother)

(Address) Elizabeth, N.J.

15 Filed 2 1927 . C. HAMPSON JONES, M. D. Registrar

Per Asst

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/11/27

17 I HEREBY CERTIFY, That I attended deceased from 12-26-26, 19 , to 1/11/27, 19 ,

that I last saw h alive on 1/11/27, 19 ,

and that death occurred, on the date stated above, at 10:30 a. m.

The CAUSE OF DEATH* was as follows:

Cardio Nephritis (Chronic Interstitial type.) (duration) 5+ yrs. mos ds.

CONTRIBUTORY (Secondary) Anemia. (duration) yrs. mos. 1 da.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. H. Jones, M. D.

, 19 (Address) Franklin Sq. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemetery

DATE OF BURIAL: Jan-12-27 19

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOOLLEN, Successor)

ADDRESS: 108 W. NORTH AVE.

Spec.—1-10-21—MAT—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17822 E 17822

CERTIFICATE OF DEATH

162

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 913 N. Vincent ST. 16-22 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth Johnson

(a) RESIDENCE NO. 913 N. Vincent ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1-9-27

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | | | 2 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Emanuel Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Ida Pider

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address)

15 Filed JAN 12 1927 C. HAMPSON JONES, M. D. Registrar

Par 0045

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1-11-1927

17 I HEREBY CERTIFY, That I attended deceased from 1-9, 1927, to 1-11, 1927, that I last saw her alive on 1-10, 1927, and that death occurred, on the date stated above, at 5:30 m.

The CAUSE OF DEATH* was as follows: (See remarks over)

Congenital atelectasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eda F. Dodge M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: JAN 12 1927

20 UNDERTAKER: Geo. Brassler Health

ADDRESS

Per. Wm. H. Woodall

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17823

## CERTIFICATE OF DEATH.

1-001

E 17823

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home & Infirmary St. 10 Ward)

(If death occurred in a hospital or institution give NAME instead of street and number.)

2-FULL NAME William M. Hesse

(a) RESIDENCE NO. 1203 E. Preston St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. 2 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) October 23 1899

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 27 | 2 | 19 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman Jr 066

(b) General nature of industry, business, or establishment in which employed (or employer) Balto Shot & Black Mfg. Co

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Charles H. Hesse

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Anna A. Mayer

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Mrs. Louis Mayer

(Address) 1203 E. Preston St

Filed JAN 13 1927 S. HAMPSON JONES, M. D. Registrar

By [illegible]

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 11, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from January 10 1927, to January 11, 1927, that I last saw him alive on January 11 1927, and that death occurred, on the date stated above, at 5 45 P m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever (duration) yrs. mos. 40 ds.

CONTRIBUTORY (Secondary) Myocardial Failure (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Blood Culture by Health Dept.

(Signed) Vernon H. Norland, M. D.

Jan 11, 1927 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery Date of Burial Jan. 14 1927

20 UNDERTAKER Henry Hosch & Son ADDRESS 130 E. Eager St

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

154-002

E 17824 E 17824

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Fairfield

CITY OF BALTIMORE: (No. 17 4½ Street ST. 25-76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel-L Baby Fay

(a) RESIDENCE NO. 17 4½ Street ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | black | single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none.

6 DATE OF BIRTH (month, day, and year) Jan. 7. 1927.

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 0 | 0 | 3 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none.

9 BIRTHPLACE (city or town) (State or country) Fairfield Md.

PARENTS

10 NAME OF FATHER Willie Fay.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mockys N.C.

12 MAIDEN NAME OF MOTHER Mattie Chesson.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mockys N.C.

14 Informant Mrs Fay (Address) Fairfield

15 Filed 1 3 1927 C. HAMPSON JONES, M. D. Registrar Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 10 1927

17 I HEREBY CERTIFY, That I attended deceased from January 7, 1927, to January 10, 1927, that I last saw him alive on January 10, 1927 and that death occurred, on the date stated above, at 4.30 P.m.

The CAUSE OF DEATH* was as follows:

Congenital Cardiac Malformation, — Atelectasis.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Patency Foramen Ovale. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) James S. Marston, M. D.

1-11 1927 (Address) 1203 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel DATE OF BURIAL Jan 13 1927

20 UNDERTAKER James A Hayes ADDRESS 142 Litchfield

pec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

17825

## CERTIFICATE OF DEATH.

31 E 17825

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2028. E. Biddle St. 6-13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anthony Weso.

(a) RESIDENCE No. 2028 E. Biddle St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, or Divorced, (write the word): Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Late Gertrude Weso.

7 DATE OF BIRTH (month, day, and year): March 15-1877

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 49 | 9 | 26 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore

10 NAME OF FATHER: John Weso

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

PARENTS

14 Informant: Margaret Perry

(Address) 2028 E. Biddle St.

15 Filed 1 3 1927 C. HAMPSON JONES, M. D. Registrar

Per

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1-11 1927

17

I HEREBY CERTIFY, That I attended deceased from 1-1, 1927, to 1-11, 1927

that I last saw him alive on 1-10-1927, 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis Mitral Regurgitation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) Thos. Burnett, M. D.

19 27 (Address) 600 W. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem

DATE OF BURIAL: 1/13 1927

20 UNDERTAKER: George J Ruth

ADDRESS: 1735 Hanford ave

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

60-001 E 17826

E 17826

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Joseph. Hospital. REGISTERED NO.

CITY OF BALTIMORE: (No. Caroline & Oliver. ST. 1-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Karwacki

(a) RESIDENCE NO. 145 S. Linwood Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | white | married. |

a If married, widowed, or divorced HUSBAND of (or) WIFE of William. Karwacki

DATE OF BIRTH (month, day, and year) Nov. 19. 1876

| AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 50 | 1 | 22. | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Poland.

PARENTS

10 NAME OF FATHER George Wikarkowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Margaret Kaszuba

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

Informant Wm Karwacki

(Address) 46 Linwood Ave

Filed JAN 13 1927 C. HARRY JONES, M. D. Registrar

Per R.R.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 10 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 9, 1927, to Jan. 11, 1927, that I last saw her alive on Jan 11, 1927, and that death occurred, on the date stated above, at 5:15a m.

The CAUSE OF DEATH* was as follows:

Toxic Goiter

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation.

(duration) yrs. mos. 1 hr.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? none.

What test confirmed diagnosis? clinical.

(Signed) A. L. McAnally, M. D.

, 19 (Address) St. Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| St Stanislaus Cem | Jan 14 1927 |
| UNDERTAKER | ADDRESS |
| Stephen J Fialkowski | 500 Kenwood Ave |

Spec.—12-9-25—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17827
1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

90

REGISTERED NO. E 17827

City of BALTIMORE: (No. 2108 Greenmount St. 12-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nannie Wilson.

(a) RESIDENCE NO. 2108 Greenmount Ave. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Female | White | Widowed |

5a If married, widowed or divorced
HUSBAND of
(or) WIFE of ~~Peter~~ Wm. Wilson.

6 DATE OF BIRTH (month, day, and year) Jan. 15, 1863.

| 7 AGE Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|
| 63 | 11 | 26 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Prop. of Notion Store.
(b) General nature of industry, business, or establishment in which employed (or employer) Notions
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Irland.

PARENTS

10 NAME OF FATHER Dennis Naughton.
11 BIRTHPLACE OF FATHER (city or town)
(State or country) Roscommon Co. Irland.
12 MAIDEN NAME OF MOTHER Nannie Naughton.
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Roscommon Co. Irland.

14 Informant John. F. Wilson.
(Address) 2108 Greenmount ave.

Filed JAN 13 1927 C. HANSON JONES, M. D. Registrar
Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19
January 11. 1927

I HEREBY CERTIFY, That I attended deceased from January 3 1927, to January 11, 1927, that I last saw h.. alive on January 11, 1927, and that death occurred, on the date stated above, at 7a m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency
2d
(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia
Arteio. Sclerosis
(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death!
Did an operation precede death! No Date of
Was there an autopsy? No.
What test confirmed diagnosis? Clinical Symptoms
(Signed) Thomas F Hicks, M. D.
, 19 (Address) 0322 E 22nd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Cathedral Cem. | 1/13 1927 |
| 20 UNDERTAKER | ADDRESS |
| Mary M. Wiedefeld. | 501 E 22 St |

Spec.—12-9-25—A Co.—200 Bks.

E 17828

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17828

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mercy Hospital

City of BALTIMORE: (No. 4-7 St. ) Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Levin

(a) RESIDENCE NO. 6801 Ellsworth Place Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yr. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Newborn

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Newborn — Years | Months | Days | IF LESS than 1 day ..... hrs. or 10 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto

PARENTS

10 NAME OF FATHER Frank Levin

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Thelma Goldman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Lake. Md.

14 Informant Hospital Record

(Address)

Filed JAN 13 1927

H. HAMILTON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 12 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan 12, 1927 to Jan 12, 1927, that I last saw h.. alive on Jan 12, 1927 and that death occurred, on the date stated above, at 6:15 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D Nolte M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Forest Rose Cem. Date of Burial: 1-13-1927

20 UNDERTAKER: Jack Levin, ADDRESS: 1479 E. Balto St.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 17829 ✓ 90 E 17829

13-59

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 308 N. Charles St. St. ____ Ward ____

2-FULL NAME Mabel Belt.

(a) RESIDENCE NO. 613 Reservoir St. St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. 9 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female.

4 Color or Race: White.

5 Single, Married, Widowed, or Divorced. (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ----------

6 DATE OF BIRTH (month, day, and year): March 19, 1887

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 39 | 9 | 22 23 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Physician.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore, Md.

(State or country)

PARENTS

10 NAME OF FATHER: William H. Belt.

11 BIRTHPLACE OF FATHER (city or town): Baltimore, Md.

(State or country)

12 MAIDEN NAME OF MOTHER: Mazie Knipp.

13 BIRTHPLACE OF MOTHER (city or town): Baltimore, Md.

(State or country)

14 Informant: Donald K. Belt. (brother)

(Address) 808 Roland Ave.

15 Filed 1927 By ____ Registrar

C. HAMPSON JONES, M. D.

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 11, 1927 19__

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism.
Mitral Stenosis.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....

(duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Steinhardt M. D.

1/12 1927 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — Date of Burial: Jan 13 1927

UNDERTAKER: [illegible] — ADDRESS: [illegible]

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17830 ✓ E 17830

## CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3038 Stricker ST., 19-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Georgett Jones

(a) RESIDENCE NO. 903 S Stricker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2/ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary E. Jones

6 DATE OF BIRTH (month, day, and year): Sept 7 1858

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 68 | 4 | 4 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Henry Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Mrs. Jones

(Address): 303 S Stricker st

JAN 13 1927

H. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 11 1927

17 I HEREBY CERTIFY, That I attended deceased from 11/26/ 1926, to Jan. 11, 1927,

that I last saw h— alive on 1/11/ 1927,

and that death occurred, on the date stated above, at 6.30 p m.

The CAUSE OF DEATH* was as follows:

Hypertension
Cerebral Hemorrhage
Myocarditis

(duration) two yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) (1 yrs.) mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? Clinical 2 30/110

(Signed) Bernard Fenn, M. D.

1927 (Address) 910 W. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn

DATE OF BURIAL: Jan 14 1927

20 UNDERTAKER: Henry Fields

ADDRESS: 1200 W Lombard

ec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17831 E 17831

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bon Secours Hospital REGISTERED NO. 74-091

CITY OF BALTIMORE: (NO. 26-10 ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. John V. Berens

(a) RESIDENCE NO. 3023 Strickland ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

6 If married, widowed, or divorced (HUSBAND) of (or) WIFE of —

DATE OF BIRTH (month, day, and year) May 21 1883

| AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 43 | 6 | 22 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wheelwright

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Machmort

BIRTHPLACE (city or town) (State or country) Balto

10 NAME OF FATHER John Berens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

PARENTS

14 Informant Henry Berens

(Address) 3023 Strickland St

15 Filed JAN 3-1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 2 , 1927, to Jan 11 , 1927, that I last saw him alive on Jan 11 , 1927, and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage (Jan 2-27

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

Onset Jan 7-27 (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Geo. D. Lipsey, M. D.

, 19 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Jan 14 19 27

20 UNDERTAKER John J. Fields — ADDRESS 1210 W Fayette

pec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17832

## CERTIFICATE OF DEATH.

91-002

E 17832

REGISTERED NO. 13-59

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2415 Eutaw Place WARD)

2-FULL NAME Joseph S. Mitnick

(a) RESIDENCE NO. 2415 Eutaw Place STREET WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henrietta Mitnick

6 DATE OF BIRTH (month, day, and year): Nov. 2, 1860

7 AGE — Years: 63 — Months: 2 — Days: 9 — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Credit + Manager

(b) General nature of industry, business, or establishment in which employed (or employer): Hecht's. 186

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): New York.

PARENTS

10 NAME OF FATHER: Harris Mitnick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland. ~~Germany~~

12 MAIDEN NAME OF MOTHER: Blakenson

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Germany.

14 Informant: Mrs. Oliner

(Address) 2415 Eutaw Place

JAN 3 1927 Filed

HAMPSON JONES, M.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jany. 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 30, 1926 to Jan 11, 1927

that I last saw him alive on Jan 11, 1927

and that death occurred, on the date stated above, at 11:20 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary): Pulmonary edema

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Nathaniel Gorh, M. D.

, 19 (Address) 710 Cuyamaca Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship Cem.

DATE OF BURIAL: 1/13/1927

20 UNDERTAKER: Harry Sondheim

ADDRESS 115-20 W. Mt. Royal Ave

Spec.—7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17833

## CERTIFICATE OF DEATH

E 17833

1-PLACE OF DEATH

REGISTERED NO. 9179

City of BALTIMORE: (No. St. Agnes Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Rose Hobeck

(a) RESIDENCE NO. 2507 Mc Henry St. 20th Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov 2nd 1922

7 AGE: Years 5 Months 1 Days 22

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) Md

PARENTS

10 NAME OF FATHER John H. Hobeck

11 BIRTHPLACE OF FATHER (City or town) Balto.

(State or country) Md

12 MAIDEN NAME OF MOTHER Marie Kodel

13 BIRTHPLACE OF MOTHER (city or town) Balto.

(State or country) Md

14 Informant Emma M. Hobeck

(Address) 2507 Mc Henry St

15 Filed JAN 3 1927 19 H. HAMPSON JONES, M. D. Registrar

FOR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 11th 19 27

I HEREBY CERTIFY, That I attended deceased from Nov 22d 1926 to January 11th 1927

that I last saw her alive on January 11th 1927

and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Sepsis

Child playing with matches - set self afire

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Burns - 2nd & 3rd Degree

(duration) yrs. 1 mos. ds.

17 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Heron Hunter M. D.

1/11, 1927 (Address) St. Agnes' Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cemetery — Date of Burial: June 5th 1927

20 UNDERTAKER: F. D. Heffner, 1850 N. Balto St — ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17834

## CERTIFICATE OF DEATH.

E 17834

1-PLACE OF DEATH Hospital for the Women of Md. 18-29 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST., WARD)

2-FULL NAME Caroline Swolvola Zylchart

(a) RESIDENCE NO. 836 W. Pratt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 5 mos. ? ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | W | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Irvin Wallace Zylchart

6 DATE OF BIRTH (month, day, and year) Aug 12/1882

7 AGE 44 Years 5 Months ? Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Charlie Swolvola

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER — unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland?

14 Informant Irvin Wallace Zylchart (Address) 836 W. Pratt St.

15 J. HAMPSON JONES, M. D. Registrar

JAN 13 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 13 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec. 31, 1926, to Jan. 13, 1927, that I last saw h[illegible] alive on Jan. 13, 1927, and that death occurred, on the date stated above, at 5:20 a m.

The CAUSE OF DEATH* was as follows:

Osteomyelitis of rt. jaw

(duration) 1 yrs. 2 mos ! ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 12/31/26

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm Wilson, M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters Cemetery DATE OF BURIAL 1/15 1927

20 UNDERTAKER W M Cook ADDRESS 831 E Mad

Spec.—7-17-26—A Co.—200 Bks.

E 17835

# HEALTH DEPARTMENT—CITY OF BALTIMORE

SE 17835

## CERTIFICATE OF DEATH

REGISTERED NO. 20-7

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hospital St. [illegible] Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Margaret Walker

(a) RESIDENCE NO. 170 Collins Ave St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James A Walker

6 DATE OF BIRTH (month, day, and year): Apr 20 1855

7 AGE: Years 71 Months 8 Days 22

IF LESS than 1 day old give hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Md

(State or country):

PARENTS

10 NAME OF FATHER: James Mukes

11 BIRTHPLACE OF FATHER (City or town): Md.

(State or country):

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): Md

(State or country):

14 Informant: Daughter Mrs Neighoff

(Address): 170 Collins Ave

15 Filed Jan 16 1927 C. HAMPSON JONES, M. D. Registrar

Per [illegible]

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 12 1927

I HEREBY CERTIFY, That I attended deceased from Jan 6, 1927, to Jan 12, 1927, that I last saw h[illegible] alive on Jan 12, 1927, and that death occurred, on the date stated above, at 11 a.m.

17 CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Fracture neck of femur, right

(duration) yrs. mos. 7 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-Ray

(Signed) Etheron Hunter M. D.

1/12/1927 (Address) St. Agnes' Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel — Date of Burial: Jan 15 1927

20 UNDERTAKER: Wm Cook — ADDRESS: 507 E Hoffman

Ok. Harold B. Norton Jr. Dec'd. Jan 12, 1927

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17836

## CERTIFICATE OF DEATH.

31 E 17836

REGISTERED NO. _____

1-PLACE OF DEATH

City of BALTIMORE: (No. 1753 Orleans St. 6-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Harvey

(a) RESIDENCE NO. 1753 Orleans St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? 1 yrs. 1 mos. _____ ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lillian Harvey

6 DATE OF BIRTH (month, day, and year): Aug 2 1883

7 AGE: Years 43 | Months 5 | Days 10 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Steel

(c) Name of employer: Bethlehem Steel Co

9 BIRTHPLACE (city or town): _____

(State or country) Va

PARENTS

10 NAME OF FATHER: Andrew Harvey

11 BIRTHPLACE OF FATHER (city or town): _____

(State or country) Va

12 MAIDEN NAME OF MOTHER: Mary Jones

13 BIRTHPLACE OF MOTHER (city or town): _____

(State or country) Va

14 Informant: Lillian Harvey

(Address) 1753 Orleans

Filed JAN 13 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Jan 12 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 4, 1927, to Jan 12, 1927, that I last saw h.. alive on Jan 11, 1927 and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 6 mos. 7 ds.

CONTRIBUTORY (Secondary) _____

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis? Sputum

(Signed) J. Smith Cox, M. D.

1-12-1927 (Address) 1126 Druid Hill

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Drakerbranch Va Date of Burial Jan 4 1927

UNDERTAKER: Sarma E. Wright ADDRESS 1364 Mary

ec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17837 — 129 E 17837

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. 23-31

CITY OF BALTIMORE: (No. 6 W. West ST., 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Wright

(a) RESIDENCE NO. 6 W. West ST. 23 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX: Female — 4 COLOR OR RACE: Colored — 5 Single, Married, Widowed, or Divorced, (write the word): married

If married, widowed, or divorced (or) WIFE of: George Wright

DATE OF BIRTH (month, day, and year): Nov 20, 1871

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 55 | 1 | 21 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: (037)

(b) General nature of industry, business, or establishment in which employed (or employer): House wife

(c) Name of employer:

BIRTHPLACE (city or town) (State or country): Frederick Md.

10 NAME OF FATHER: John Skinner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Frederick Md

12 MAIDEN NAME OF MOTHER: Tillie Waters

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Frederick Md

PARENTS

14 Informant: Bureau Vitals (Address): 1310 Penna Ave

15 Filed ... 19 ... CHAMP M. JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/10/1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 27, 1926, to Jan 10, 1927, that I last saw her alive on Jan 10, 1927, and that death occurred, on the date stated above, at 2.45 p. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation with Pulmonary Apoplexy

(duration) yrs mos 2 ds.

CONTRIBUTORY (Secondary) Acute Parenchymatous Degeneration (duration) yrs. 2 mos. 17 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? History & Physical

(Signed) Wm. M. Bishop, M. D.

1-11, 1927 (Address) 709 Hollins St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: Jan 3 1927

20 UNDERTAKER: Sam'l N. Carter — ADDRESS: 400 Madison

Spec.—8-24-14—M. & T.—2000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17838

## CERTIFICATE OF DEATH.

90

E 17838

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1620 Friendship St. 15-21 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Max Jahren

(Residence in Baltimore: No. 1620 Friendship St. 48 yrs., ...mos.,...ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) married

6-DATE OF BIRTH, ....., 1853
(Month) (Day) (Year)

7-AGE. 43 yrs. ...mos. ...ds.

If LESS than 1 day, ....hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Salesman
(b) General nature of industry, business, or establishment in which employed (or employer): ...

9-BIRTHPLACE, (State or Country). Austria

PARENTS.

10-NAME OF FATHER. Louis Scholer

11-BIRTHPLACE OF FATHER (State or Country). Austria

12-MAIDEN NAME OF MOTHER Spindel

13-BIRTHPLACE OF MOTHER (State or Country). Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Hattie Scholer

(Address) 1620 Friendship st

15- JAN 3 1927 C. HAMPSON JONES, M. D., 191..., Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 12, 1927.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 15 1926, to January 12 1927, that I saw h.. alive on January 11 1927, and that death occurred, on the date stated above, at ...m.

The CAUSE OF DEATH* was as follows:

.....

Old age

..... (Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(Duration) ...yrs. 2 mos. ...ds.

(Signed) Jul R. Bolgiano M. D.

January 13 1927 (Address) 1345 N. Bentalou

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1620 Friendship st

19-PLACE OF BURIAL OR REMOVAL. Edgewood Rosedale — DATE OF BURIAL. 1 13, 1927

20-UNDERTAKER Sol Levinson Bro — ADDRESS 1127 E Balto st

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17839

## CERTIFICATE OF DEATH.

E 17839

1-PLACE OF DEATH 1612 E Madison St

REGISTERED NO. 7-13 57

CITY OF BALTIMORE: (No. ..... ST., ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary M. Distance ~~Easton Avenue Road~~

(a) RESIDENCE NO. ~~1612 E. Madison~~ ST., ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Colored | Married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Joseph L Distance

6 DATE OF BIRTH (month, day, and year) Nov. 19 1878

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 48 | 1 | 21 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Alex. Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Matilda Jefferson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mabel Howard

(Address) 1612 E. Madison St

15 Filed JAN 13 1927, 19 ... By ... Registrar

C. HARPOON JONES, M.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1—10 1927

17 I HEREBY CERTIFY, That I attended deceased from 1—8— 1927 to 1—10 1927.

that I last saw her alive on 1—10 1927

and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Diabetic Coma

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical — Febrility

(Signed) W. B. Butler, M. D.

19 (Address) 425 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Leakin Cemetery | 1/13 [illegible] |
| 20 UNDERTAKER | ADDRESS |
| Wm. R. G. Elliott | 1911 Eastland Ave |

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17840

## CERTIFICATE OF DEATH.

31

E 17840

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1600 Madison Ave St. 14-70 Ward)

2-FULL NAME Ruby Robinson

(a) RESIDENCE NO. 1600 Madison Ave St._____ Ward_____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | colored | single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 7 1907

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 20 | | | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 010
(c) Name of employer

9 BIRTHPLACE (city or town)_____
(State or country) Va.

PARENTS

10 NAME OF FATHER Edward Robinson
11 BIRTHPLACE OF FATHER (city or town)_____
(State or country) Thorbud Va
12 MAIDEN NAME OF MOTHER Virgie Crenshaw
13 BIRTHPLACE OF MOTHER (city or town)_____
(State or country) Thorbud Va

14 Informant Lella Robinson
(Address) 1600 Madison Ave

Filed JAN 13 1927 Per _____ Registrar

C. HAMPSON JONES, M. D.

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 12 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pul. Tuberculosis

(duration) ____ yrs. 9 mos. ____ ds.

CONTRIBUTORY (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) C. E. Hennessy M. D.
(Coroner)

Jan. 12, 1927 (Address) 2707 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ____ yrs., ____ mos., ____ ds. In the State ____ yrs., ____ mos., ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Thorbud Virginia — Date of Burial 1/13 1927

20 UNDERTAKER Samuel D. Hennessy — ADDRESS 578 W Biddle

ec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 17841 — 100-001 — E 17841

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 865 W Lexington ST. 18-26 (WARD)

2-FULL NAME Richard Burton

(a) RESIDENCE NO. 865 W Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Oct 14-24

| AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 2 | 2 | 29 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Laurence Burton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Nellie Bell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Nellie Burton

(Address) 865 W Lexington St

Filed 3 1927, 19 Per C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 12 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 9 .1927. to Jan 12 .1927.

that I last saw h[illegible] alive on Jan 12 .1927

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H. Klauber, M. D.

, 19 (Address) 163 George

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Mt. Auburn Cem | Jan 13 19 27 |

20 UNDERTAKER Samuel G Stanley

ADDRESS W Biddle

Spec.—12-9-25—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17842

## CERTIFICATE OF DEATH.

6-10 129

E 17842

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2125 Jefferson St., 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME G. William Snyder

(a) RESIDENCE NO. 2125 Jefferson St. Ward

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mollie Roberta Snyder

6 DATE OF BIRTH (month, day, and year): Aug. 25 1854

7 AGE: Years 72 | Months 4 | Days 17 | If LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Clerk

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.

(State or country)

PARENTS

10 NAME OF FATHER Peter Snyder

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Christina Kleinow

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant: Mollie R. Snyder

(Address) 2125 Jefferson St

Filed JAN 3 1927 C. HAMPSON JONES, M. D. Registrar

Per R.H.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 1927, to Jan 11, 1927, that I last saw h[illegible] alive on Jan 11, 1927, and that death occurred, on the date stated above, at 11 50 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Senum Int. Nephritis Arterio Sclerosis + Impaired Liver

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Alan B Lemmon, M. D.

1/12 1927 (Address) 718 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery Date of Burial Jan 14 1927

20 UNDERTAKER: Chas F. Krause & Son ADDRESS 1817 W. Mt. Royal Ave

Dec.—1-12-23—M&T—500 Bks.

(Annie Mollock)

E 17843

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17843

## CERTIFICATE OF DEATH.

REGISTERED NO. 118

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. 1349 E. Carey ST. 15-21 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Mollock

(a) RESIDENCE NO. 1349 E. Carey ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | colored | married |

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Issaac -

DATE OF BIRTH (month, day, and year) 1867

| AGE | Years | Months | Days | If LESS than 1 day.....hrs. or min. |
|---|---|---|---|---|
| 60 | 59 | | | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work N. Wr. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Va -

10 NAME OF FATHER not known

11 BIRTHPLACE OF FATHER (city or town) not known (State or country)

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) not known (State or country)

PARENTS

14 Informant Records JOHNS HOPKINS HOSPITAL (Address)

15 Filed JAN 31 1927 C. HAMPSON JONES, M. D. Registrar By RH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 8, 1927, to Jan, 1927, that I last saw h[illegible] alive on Jan, 1927 and that death occurred, on the date stated above, at 7 [illegible] a m.

The CAUSE OF DEATH* was as follows:

Strangulated femoral hernia

Intestinal obstruction

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

Terminal (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Ward

Did an operation precede death? Yes Date of 1/8/27

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) Warfield Interne, M. D.

, 19 (Address) JHH

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL Jan 14 1927

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Pennsylvania Ave

Spec.—1-10-21—M&T—1500 Bks.

# E 17844 HEALTH DEPARTMENT—CITY OF BALTIMORE

161-002

E 17844

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Md. Gen. Hospital ST. 11-24 WARD REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.)

2-FULL NAME Baby Gosnell

(a) RESIDENCE NO. Reisterstown Rd. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | Mulatto | Baby |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1-12-27.

| 7 AGE | Years | Months | Days | If LESS than 1 day ... hrs. or ... min. |
|---|---|---|---|---|
| | ✓ | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER S. N. Gosnell

11 BIRTHPLACE OF FATHER (city or town) Balto County
(State or country)

12 MAIDEN NAME OF MOTHER Bessie F Durham

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Mrs. Bessie Gosnell
(Address) Reisterstown Md

15 Filed 1-13 1927, 19 C. HAMPSON JONES, M. D. Registrar
Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-12 1927

17 I HEREBY CERTIFY, That I attended deceased from 1-12, 19 27, to 1-12, 19 27,

that I last saw h[illegible] alive on 1-12, 19 27

and that death occurred, on the date stated above, at 5:08 m.

The CAUSE OF DEATH* was as follows:

Difficult Labor
Asphyxia Neonatorum
Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of 1-12-27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jay Townsend Gosnell M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Woodlawn M E Cemetery | June 3 1927 |

20 UNDERTAKER ADDRESS

J. F. Elliott & Sons Reisterstown Md

Cor.—12-9-25—A Co.—200 Bks.

Montvadi

# HEALTH DEPARTMENT—CITY OF BALTIMORE

90

17845

## CERTIFICATE OF DEATH.

E 17845

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3440 Phila Rd 26-11 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Geo Mosthworde

(a) RESIDENCE NO. 3440 Phila Rd. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced (write the word): S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 19-1856

7 AGE: Years 70 Months Days 21 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) Unk.

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Italy

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Italy

14 Informant Mrs Clara C Stenger

(Address) 3440 Phila ave

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

NOV 13 1927

Per —

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Mitral Stenosis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) & Cirrhosis

(duration) yrs. mos. 1 ds.

(Signed) G. P. Wade M. D.

(Coroner)

19 (Address) 143 W Eager

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.,.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery Date of Burial 11/13/1927

20 UNDERTAKER J. A. Inman ADDRESS 3000 E Baltimore

Spec—12-23-21—E.B.R.S.—400 Bks.

E 17846

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 17846

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 208 Popleton St., Ward 18-26) Registered No. 99

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Annie Griffin

(a) Residence No. 208 Popleton St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced. (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 53 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Domestic

(b) General nature of industry, business, or establishment in which employed (or employer). Laundress

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Eastern Shore, Md.

PARENTS.

10-NAME OF FATHER. Richard Clayton

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Eastern Shore Queen Anne, Md

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Queen Anne Co. Md

14- (Informant). Jemiah Griffin

(Address). 208 N. Popleton St.

15- Filed JAN 3 1927 C. HAMPSON JONES, M.D. Registrar

By [illegible]

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 10/1927

17- I HEREBY CERTIFY, That I attended deceased from Dec 24 1926 to Jan 10 1927 that I last saw her alive on Jan 10 1927 and that death occurred, on the date stated above, at 2.50 P m.

The CAUSE OF DEATH* was as follows:

Bronchiectasis

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Decomposition Cardiac

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) 704 W Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. McCubrin

DATE OF BURIAL. 1/13/27 19

20-UNDERTAKER. Katie R. Williams

ADDRESS 922 N. Schroeder St.

ec.—1-12-23—M&T—500 Bks.

Patterson

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17847

## CERTIFICATE OF DEATH.

101-001

E 17847

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 405 N. Parrish St. (Ward) 19-27

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Patterson

(a) RESIDENCE NO. 405 N. Parrish St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. 7 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Negro | married |

If married, widowed, or divorced HUSBAND of (or) WIFE of Mamie Patterson

DATE OF BIRTH (month, day, and year) March (?) 1886

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 40 | 9 | 7 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) General

(c) Name of employer J. Flanagan

BIRTHPLACE (city or town) (State or country) Westmoreland Co. Va

10 NAME OF FATHER William Patterson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Winters

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Mamie Patterson (wife)

(Address) 405 N. Parrish

Filed JAN 3 1927 C. HAMPSON JONES, M.D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 7, 19 27, to Jan 10, 19 27,

that I last saw him alive on Jan 10, 19 27,

and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

I. (a) Pneumonia Bilateral

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? Date of

Was there an autopsy? Physical Exam

What test confirmed diagnosis?

(Signed) Walter Foreman, M. D.

, 19 (Address) 6 W. Hoffman St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Lion Cemetery

DATE OF BURIAL Jan. 13 1927

UNDERTAKER Mrs. Katie R. Williams

ADDRESS 522 N. Schroeder St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Crisafulle ✓

# HEALTH DEPARTMENT—CITY OF BALTIMORE

17848
1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

49 E 17848
REGISTERED NO.

CITY OF BALTIMORE: (NO. 146 N. Exeter ST. 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cristafulli, Paulina

(a) RESIDENCE. NO. 146 N. Exeter ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Female | W | Child |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 23. 1920

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 6 | 7 | 19 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Sebastiano Crisafulle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Luisa Sanzone

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Sebastiano Crisafulle
(Address) 146. N. Exeter St.

15 Filed JAN 13 1927 C. HAMPSON JONES, M. D., Registrar
By —

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-12 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1 1926 to Jan. 12 1927

that I last saw h— alive on Dec. 29. 1926.

and that death occurred, on the date stated above, at 7P. m.

The CAUSE OF DEATH* was as follows:

Sarcoma, left femur

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No. + X rays

What test confirmed diagnosis? Clinical findings

(Signed) H. W. Cirlis, M. D.

1/12, 1927 (Address) 1300 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Holy Redeemer Cemetery | 1/13 1927 |
| 20 UNDERTAKER | ADDRESS |
| Geo J Ruth | 1735 Harford ave |

Spec.—1-10-21—M&T—1500 Bks.

17849

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17849

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 826 E. Baltimore ST., 5-8 WARD) REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Meyer Fookman

(a) RESIDENCE NO. 826. E. Baltimore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? 17 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of): Sylvia Fookman

6 DATE OF BIRTH (month, day, and year): 1876

7 AGE: Years 51 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Grocer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Benj D Fookman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Fookman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Sylvia Fookman 826 E Balto St

15 [illegible]

1 3 1927

C. HAMPSON JONES, M. D., Registrar

Per [illegible]

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 13 1927

17

I HEREBY CERTIFY, That I attended deceased from Dec. 16, 1926, to January 13, 1927, that I last saw h[illegible] alive on January 12, 1927 and that death occurred, on the date stated above, at 4 [illegible] m

The CAUSE OF DEATH* was as follows:

Chronic myocarditis
aortic insufficiency
myocardial insufficiency

(duration) 1 yrs. 7 mos ds.

CONTRIBUTORY (Secondary): acute diffuse nephritis

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical exam. Urinalysis

(Signed) Isador M Miller M. D.

1/13, 1927 (Address) 1613 Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rehren Hebrew Rm

DATE OF BURIAL: 1/13 1927

20 UNDERTAKER: Jack Louis

ADDRESS: 1434 E Balto St

Spec.—12 9-25—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

99-001

E 17850

## CERTIFICATE OF DEATH.

REGISTERED NO. E 17850

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor St. 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Timothy Brown

(a) RESIDENCE NO. Preston & Valley St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 1st 1852

7 AGE: 74 Years | Months: 8 | Days: 10 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Ireland

PARENTS

10 NAME OF FATHER Charles Brown

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Kenderick

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Ireland

14 Informant: Little Sisters of the Poor

(Address) Preston & Valley St.

15 Filed Jan 13 1927 By C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 Jan 11

17 I HEREBY CERTIFY, That I attended deceased from No Record, 19..., to ..., 19...,

that I last saw h... alive on Jany 11, 1927,

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) ...yrs. ...mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Warner, M. D.

Jany 12, 1927 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Peters — Date of Burial: Jan 14 1927

20 UNDERTAKER: Rita V. Rudefeld — ADDRESS: 914 Fremont Ave

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17851

## CERTIFICATE OF DEATH.

118-002

E 17851

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Maryland General Hospital ST. WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Marion Babylon

(a) RESIDENCE NO. Westminster, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: D. Snider Babylon

6 DATE OF BIRTH (month, day, and year): April 20, 1888

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 38 | 8 | 22 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (City or town) (State or country): Westminster Md.

PARENTS

10 NAME OF FATHER: Harry Cover

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Lolard Hitesher

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mrs. Marion Babylon

(Address) Westminster Md

15 Filed: NOV 3 1927 C. HAMPSON JONES, M. D. Registrar

For

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 12 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 9, 1927, to Jan 12, 1927,

that I last saw h[illegible] alive on 11 12, 1927,

and that death occurred, on the date stated above, at 1 18 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Peritonitis general

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Jan. 9, 1927

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. C. Zimmerman M. D.

, 19 (Address) Md. Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westminster Snider's

DATE OF BURIAL: 1/14 1927

20 UNDERTAKER: H Bankard & Son

ADDRESS: Westminster Md

Spec.—1-10-21 M&T 1500 Blks.

# E 17852 HEALTH DEPARTMENT—CITY OF BALTIMORE E 17852

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals REGISTERED NO. 16-26 38

CITY OF BALTIMORE: (No. Baltimore, Md. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Dixon

(a) RESIDENCE NO. 634 N.Fremont Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Black | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Dixon

6 DATE OF BIRTH (month, day, and year) 1879

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs or ..... min. |
|---|---|---|---|---|
| | 48 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) Porter

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Dixon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Linda

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Baltimore City Hospitals. (Address) Baltimore, Md.

15 1-3 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-10- 1927

17 I HEREBY CERTIFY, That I attended deceased from 10-6- , 1926 , to 1-10- , 1927, that I last saw him alive on 1-9- , 27 , and that death occurred, on the date stated above, at 9.10 A. M.

The CAUSE OF DEATH* was as follows:

General Paralysis of the Insane

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Luetic Infection.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Serological and Clinical Findings

(Signed) John Goedomet M D.

1/10/1927 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Road DATE OF BURIAL 1/14 1927

20 UNDERTAKER Samuel T. Hemsley ADDRESS 5-78 N. Biddle

Spec.—1-10-21—M&T—1500 Bks.

E 17853 HEALTH DEPARTMENT—CITY OF BALTIMORE E 17853

CERTIFICATE OF DEATH

15-60 91-002

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1806 Ashburton ST. WARD)

2-FULL NAME Mrs. Louise G. Bolton

(a) RESIDENCE No. 1806 Ashburton ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas J. Bolton

6 DATE OF BIRTH (month, day, and year): Dec 17-1845

7 AGE: Years 81 Months — Days 23 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Anthony Bolton

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Tirner Holt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: Mrs. Thomas J. Bolton (Address) 1806 Ashburton St.

15 JAN 13 1927 C. HAMPSON JONES, M. D. Per [illegible] Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 12 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1926, to Jan 12, 1927, that I last saw him alive on Jan 11, 1927, and that death occurred, on the date stated above, at 3 20 A m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis.

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Ex.

(Signed) J. M Lundquist M. D.

1/13 1927 (Address) 826 N Carrollton Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery DATE OF BURIAL Jan. 14 1927

20 UNDERTAKER: George L. Edmonds ADDRESS 210 E. Fayette St.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17854

## CERTIFICATE OF DEATH.

E 17854

51

REGISTERED NO. 24-34

1-PLACE OF DEATH

City of BALTIMORE: (No. 1435 Riverside Ave. Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Michael J. Brannan

(a) RESIDENCE NO. 1435 Riverside Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amelia Miller Brannan

6 DATE OF BIRTH (month, day, and year) June 17th 1848

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 78 | 6 | 25, 24 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Retail Coal Dealer

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Ireland,

PARENTS

10 NAME OF FATHER Jas. Brannan

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Mrs Amelia M Brannan

(Address) 1435 Riverside Ave,

15 Filed JAN 21 1927 C. HAMPSON JONES, M. D., Registrar

Per ARR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 2 1927, to Jan 11, 1927, that I last saw h.. alive on Jan 11, 1927, and that death occurred, on the date stated above, at 2.10 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy -

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Diabetes & Arterio Sclero

duo (duration) 2 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. Hampson Jones, M. D.

1/12 1927 (Address) 1 E Randall Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem Date of Burial Jan 14 1927

20 UNDERTAKER Margaret L. Flynn ADDRESS 1422 Light St.

Spec.–7-17-26—A Co.—200 Bks.

E 17855

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17855

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hospital St., Ward

REGISTERED NO. 25-72

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul Broccuse

(a) RESIDENCE NO. Marcottsville, Md St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 7 ds.

(If non-resident give city or town and State)

How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 1915.

7 AGE — Years: 8 Months: 3 Days: — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Md.

9 BIRTHPLACE (city or town) Howard Co.

(State or country)

PARENTS

10 NAME OF FATHER Harry Broccuse

11 BIRTHPLACE OF FATHER (City or town) Balto.

(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary O'Neill

13 BIRTHPLACE OF MOTHER (City or town) Howard Co.

(State or country) Md

14 Informant Harry Broccuse

(Address) Marriottsville

3 1927 C. HAMPSON JONES, M. D.

Per AKB Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 1-13-27

17 I HEREBY CERTIFY, That I attended deceased from 1-4, 1927, to 1-13, 1927,

that I last saw him alive on 1-13, 1927,

and that death occurred, on the date stated above, at 2-30 P. m.

The CAUSE OF DEATH* was as follows:

Otitis Media Purulent - acute.

(duration) yrs. mos. 4 da.

CONTRIBUTORY (Secondary) Streptococcic Meningitis.

(duration) yrs. mos. 7 da.

18 Where was disease contracted if not at place of death? Marriottsville, Md.

Did an operation precede death? yes Date of 1-5-27

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) O. J. Knapp, M. D.

1-13-1927 (Address) St Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. St. Johns Cem.

Date of Burial: 1-16-27

20 UNDERTAKER: Carton Sons Co.

ADDRESS

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 17856 × 29 E 17856

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hoslital St., 7-9 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Catherine Lewis

(a) RESIDENCE NO. Bel Air Md St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | Col | single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXX

6 DATE OF BIRTH (month, day, and year) Jan 15/25

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 1 | 11 | 29 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Bel Air Md

PARENTS

10 NAME OF FATHER Robert Beard

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Mable Lewis

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) MD

14 Informant John W. Lewis (Grandfather)

(Address) Bel Air Md.

3 1927 C. HAMPSON JONES, M. D.

Per _____ Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 13/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Terminal Bronchopneumonia

(Possible Tetanus)

(Autopsy at Hopkins)

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Ricketts-History of acc

Burn 3 Weeks (duration) .....yrs. .....mos. .....ds.

(Signed) J. M. Baer, M. D.

(Coroner)

1/23/27 (Address) 508E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19) PLACE OF BURIAL, CREMATION OR REMOVAL Harford Memorial Harford Co Md Date of Burial Jan 15 1927

20 UNDERTAKER Dean & Foster ADDRESS Bel Air Md

very important.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 17857

E 17857

REGISTERED NO. 13-52

1-PLACE OF DEATH

City of BALTIMORE: (No.) 435 Falls Road St., (Ward) 12

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sidney L. Gaffney

(a) RESIDENCE NO. 3122 Grace St. Richmond Va. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female — 4 Color or Race White — 5 Single, Married, Widowed, or Divorced. (write the word) Widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of James Gaffney

6 DATE OF BIRTH (month, day, and year) March 1-1841

| 7 AGE | Years | Months | Days | If LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 85 | 10 | 11 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland

(State or country)

PARENTS

10 NAME OF FATHER [illegible] Lee

11 BIRTHPLACE OF FATHER (city or town) Unknown

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown

(State or country)

14 Informant Mrs. Rebecca Ryburg

(Address) Richmond Va.

I[illegible] 1927 C. HAMPSON JONES, M. D., Registrar

Per ACH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 12- 1927

17 I HEREBY CERTIFY, That I attended deceased from 1-8 1927, to 1-12, 1927, that I last saw h[illegible] alive on 1-12, 1927, and that death occurred, on the date stated above, at 12 Noon

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Grippe

(duration) yrs. mos. 4 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Richard Dixon, M. D.

, 19 (Address) 427 Mosher St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Date of Burial Jan. 14 1927

20 UNDERTAKER Horace H. Burgee ADDRESS 3631 Falls Rd.

Spec.—1-10-21 M&T 1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17858

## CERTIFICATE OF DEATH.

11-001 E 17858

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1118 Brent ST. 724 WARD)

2-FULL NAME mrs. D. Allen

(a) RESIDENCE NO. 1118 Brent ST., ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Fmale | col | widow |

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Edith Allen

6 DATE OF BIRTH (month, day, and year) 1883

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs or min. |
|---|---|---|---|---|
| | 44 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) new Jersey

PARENTS

10 NAME OF FATHER mr Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Jersey

12 MAIDEN NAME OF MOTHER Edith Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. J.

14 Informant Emma D Keefe

(Address) 1118 Brent st

15 JAN 3 1927 C. HAMPSON JONES, M. D. Registrar

By .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 27, 1926, to Jany 11, 1927.

that I last saw him alive on Jany 10, 1927.

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Influenza. (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of no

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) David Wright M. D.

1/2, 1927 (Address) 1106 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem DATE OF BURIAL Jan 13 1927

20 UNDERTAKER Wm. J. Easton & Bro. ADDRESS 916

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17859

## CERTIFICATE OF DEATH.

90 E 17859

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1407 Argyle Ave St. 14-20 Ward)

2-FULL NAME Chas. H. Gannon

(a) RESIDENCE NO. 1407 Argyle Ave, St. _____ Ward _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | colored | single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1866

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 61 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer) Hotel

(c) Name of employer General

9 BIRTHPLACE (city or town) _____
(State or country) Md.

PARENTS

10 NAME OF FATHER Chas Gannon

11 BIRTHPLACE OF FATHER (city or town) _____
(State or country) Md.

12 MAIDEN NAME OF MOTHER _____

13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country) _____

14 Informant Chas H. Gannon
(Address) 1407 Argyle ave

15 Filed Jan 3 1927 C. HAMPSON JONES M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) ___ yrs. 2 mos. ___ ds.

CONTRIBUTORY (Secondary) Senility

(duration) ___ yrs. ___ mos. ___ ds.

(Signed) Jos. [illegible], M. D.
(Coroner)

Jan 1, 19 27 (Address) 2802 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters Cem Date of Burial Jan 13/27 19

20 UNDERTAKER Daniel Easton ADDRESS 916 Eager St

Spec.—1;12-23—M&T—500 Bks.

17860 HEALTH DEPARTMENT—CITY OF BALTIMORE E 17860

CERTIFICATE OF DEATH. 31

1-PLACE OF DEATH U.S. Marine Hospital No 1 REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore, Md. ST., 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfred Zamero

(a) RESIDENCE NO. 1 So Ann Bath. Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. — mos. 7 ds. How long in U. S., if of foreign birth? 10 yrs. — mos. — ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1887

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 40 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman O.S.

(b) General nature of industry, business, or establishment in which employed (or employer) Steward

(c) Name of employer S/S Byron W. Benson

9 BIRTHPLACE (city or town) (State or country) Trieste, Austria

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed JAN 3 1927 19 C. HAMPSON JONES, M. D. Registrar

Per —

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June. 12 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 13, 1926, to Jan. 12, 1927, that I last saw h[illegible]ive on Jan. 12, 1927, and that death occurred, on the date stated above, at 10 15 a.m.

The CAUSE OF DEATH* was as follows:

Diathesis Hemorrhagic

(duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis Chronic, Pulmonary

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings + Laboratory tests

(Signed) J. W. Bevelo, M. D.

, 19 (Address) Asst Surgeon. U.S. Marine Hospital #1 Baltimore, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dr Marys Hampden DATE OF BURIAL Jan 14 1927

20 UNDERTAKER E. LeRoy Steffler ADDRESS 1258 Hall ave

Cor.—I-12-23—M&T—100 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

17861 — 186-003 — E 17861

## CERTIFICATE OF DEATH.

REGISTERED NO. 9446

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Falls Road North (ST.) (WARD)

2-FULL NAME George Edgar Price

(a) RESIDENCE NO. 541 W 27th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Married

If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Price

DATE OF BIRTH (month, day, and year): Sept 27 1864

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 62 | 3 | 14 | |

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Railroad
(b) General nature of industry, business, or establishment in which employed (or employer): Track walk.
(c) Name of employer

BIRTHPLACE (city or town) (State or country): Md

10 NAME OF FATHER: William Price

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Margaret Fall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

Informant: Mary Price
(Address): 541 W 27

Filed 3 1927, 192 — C. HAMPSON JONES, M.D., Registrar
By NKW

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/11 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to h death on the day stated above.

The CAUSE OF DEATH* was as follows: Injuries Due to Auto Accident

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) [illegible], M. D. (Coroner.)

, 192 (Address) 762 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Mayo Hampde | Jan 14 1927 |

20 UNDERTAKER: E. LeRoy Stiffler — ADDRESS: 1255 Hall

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17862 — CERTIFICATE OF DEATH. — E 17862

REGISTERED NO. _____

1-PLACE OF DEATH Mercy Hospital

City of BALTIMORE: (No. _____ St. _____ Ward) 4-7

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Grunsfelder

(a) RESIDENCE NO. Oriole Av. Back River Md. Ward 1

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occ... yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Matilda Grunsfelder

6 DATE OF BIRTH (month, day, and year): Aug 3 - 1886

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 40 | 5 | 9 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Cont Con Co

9 BIRTHPLACE (city or town): Balto

(State or country): Md

PARENTS

10 NAME OF FATHER: Joseph A. Grunsfelder

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Anna C Owens

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Balto Md.

14 Informant: Thomas Grunsfelder

(Address): 3118 Hudson St.

Filed 3 1927

C. HAMPSON JONES, M. D. Registrar

By ACA

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/12 1927

17 I HEREBY CERTIFY, That I attended deceased from 1/10, 19 27, to 1/12, 19 27

that I last saw h... alive on 1/12, 19 27

and that death occurred, on the date stated above, at 10:15 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Lobar Pneumonia

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary): Uremia

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E Winter, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cemetery — Date of Burial 1/15 1927

20 UNDERTAKER: Wm Cook — ADDRESS Sorrento

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 17863

90 E 17863

8-16

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2327 E. Oliver St St., ____ Ward)

2-FULL NAME Elizabeth Smith

(a) RESIDENCE NO. 2327 E. Oliver St. St.____ Ward____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 4 mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | white | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick Smith

6 DATE OF BIRTH (month, day, and year) Sept 1868

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 58 | 4 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md.

(State or country)

PARENTS

10 NAME OF FATHER John Volmer

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Frederick Smith

(Address) 2327 E. Oliver St

3 1927 C. HAMPSON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 12/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Probably Myocardial Insufficiency

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) ___

(duration) ___ yrs. ___ mos. ___ ds.

(Signed) J. Ed Pallen M. D.

(Coroner)

1/13/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted, if not at place of death? ___

Former or usual residence ___

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Gan Date of Burial 1 14 1927

20 UNDERTAKER John C Miller ADDRESS 2435 E Oliver St

E 17864

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17864

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 931 Fell St. 2-4 Ward) 90 Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alexander Gas

(Residence in Baltimore: No. 931 Fell St.; yrs. 21 mos. 1 ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

| 3-SEX | 4-COLOR OR RACE | 5-Single, Married, Widowed, or Divorced. (Write the word.) |
|---|---|---|
| M | W | Divorced |

6-DATE OF BIRTH, April (Month) 10 (Day) 1876 (Year)

| 7-AGE | If LESS than 1 day, |
|---|---|
| 50 yrs. 9 mos. 1 ds. | ....hrs. or....min.? |

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Labor
(b) General nature of industry, business, or establishment in which employed (or employer): Odd

9-BIRTHPLACE, (State or Country). Poland

PARENTS.

10-NAME OF FATHER. Stanislaus Gas

11-BIRTHPLACE OF FATHER, (State or Country). Poland

12-MAIDEN NAME OF MOTHER. Felicia Podles

13-BIRTHPLACE OF MOTHER, (State or Country). Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Sophia Gas

(Address) 931 Fell St

15-

Filed 3-1927 C. HAMPSON JONES, M. D. Registrar.

Per .....

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 11 (Day) 192 7 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arterial Sclerosis

(Duration) ....yrs.... mos. 1 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(Duration) ....yrs.... mos. 1 ds.

(Signed) J. C. Hampson M. D.

(Coroner.)

192 (Address) 931 Fell St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

| 19-PLACE OF BURIAL OR REMOVAL. | DATE OF BURIAL. |
|---|---|
| Holy Rosary | Jan 14 192 7 |
| 20-UNDERTAKER. John M. Welsh | ADDRESS 1803 Bank |

Spec.—1-12-23—M&T—500 Bks.

17865

# HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 17865

## CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 106 Altona Ave. ST. 27-43 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Harry Drebing

(a) RESIDENCE NO. 106 Altona Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia E. Drebing

7 DATE OF BIRTH (month, day, and year) April 16, 1885

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min |
|---|---|---|---|---|
| | 41 | 8 25 | 16 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Low Electric Co.,

9 BIRTHPLACE (city or town) (State or country) Baltimore Co., Md.

PARENTS

10 NAME OF FATHER George Milton Drebing

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Murray

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Mrs. Julia E. Drebing (Address) 106 Altona Avenue

15 Filed JAN 13 1927, 19 Per C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 11 19 27

17 I HEREBY CERTIFY, That I attended deceased from Jan 9, 19 27, to Jan 11, 19 27, that I last saw him alive on Jan 11, 19 27, and that death occurred, on the date stated above, at 4.15 p. m.

The CAUSE OF DEATH* was as follows: Acute Cardiac Dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas Jones, M. D.

Jan. 12/27 (Address) 4706 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL Jan. 14 19 27

20 UNDERTAKER Joseph B. Cook

ADDRESS 1053 N. Gaits St.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17866

## CERTIFICATE OF DEATH.

90 E 17866

1-PLACE OF DEATH Baltimore & Payson Sts. REGISTERED NO.

City of BALTIMORE: (No. German Aged Home St., 70-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Schmidt

(a) RESIDENCE NO. German Aged Home St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mns. ds. How long in U. S., if of foreign birth? 80 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Schmidt

6 DATE OF BIRTH (month, day, and year) March 30 1843

| 7 AGE Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|
| 83 | 9 | 13 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of indnstry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Henrich Lenker

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Margaretha Block

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant German Aged Home (Records)

(Address) Balto & Payson Sts

3 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 12th 19 27

17 I HEREBY CERTIFY, That I attended deceased from Feb. 14th 1925 to Jan 12 1927, that I last saw her alive on Jan 11th 1927, and that death occurred, on the date stated above, at 3 30 a. m.

The CAUSE OF DEATH* was as follows: Valvular Heart Disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Aortic Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John Nauff, M. D.

, 19 (Address) 1843 W Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dr. Walters Clan Date of Burial Jan 4 1927

20 UNDERTAKER Joseph B Cole ADDRESS 1003 W Balto St

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17867

## CERTIFICATE OF DEATH.

100-001 E 17867

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1906 Hanover St. ST. ... WARD 23-32

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gottfred C. Stamm

(a) RESIDENCE No. 1906 Hanover St. ST., .... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Marie Stamm

6 DATE OF BIRTH (month, day, and year) June 21 1862

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 64 | 6 | 20 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Mutual Chemical Co

9 BIRTHPLACE (city or town) (State or country): Switzerland

PARENTS

10 NAME OF FATHER: Klemm Stamm

11 BIRTHPLACE OF FATHER (city or town) (State or country): Switzerland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Switzerland

14 Informant: Mrs. Marie Stamm (Wife)

(Address) 1906 Hanover St.

15 Filed JAN 4 1927, 19 C. HAMPSON JONES, M. D. Registrar

Per RR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 4, 1927, to Jan 11, 1927.

that I last saw h alive on Jan 11, 1927

and that death occurred, on the date stated above, at 5.10 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. R. Campbell, M. D.

Jan 12 1927 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery

DATE OF BURIAL: Jan. 15' 27

20 UNDERTAKER: Nelson E Stiles

ADDRESS 231 Md Ave Westport

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17868

## CERTIFICATE OF DEATH.

101-001 E 17868

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. House of the Good Shepherd Mount & Hollins Sts. St. 19-28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie C. Shadie

(a) RESIDENCE NO. Mount & Hollins Sts. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. 10 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| F | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 29th, 1861

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 65 | 1 | 14 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Rockland,

(State or country) Maine

PARENTS

10 NAME OF FATHER John Shadie

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Mother M. of St. Josepha

(Address) Mount & Hollins Sts.

Filed JAN 14 1927 C. HAMPSON JONES, M. D. Registrar

Per R.H.C.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 12th 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1927, to Jan 12th, 1927, that I last saw h.... alive on Jan 12th, 1927, and that death occurred, on the date stated above, at 8:20 P. m.

The CAUSE OF DEATH* was as follows: Acute Lobar Pneumonia

(duration) ... yrs. ... mos. 9 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 10 yrs. ... mos. ... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & symptoms

(Signed) J. A. Calstad, M. D.

Jan 13, 1927 (Address) 1300 N Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. Date of Burial 1/14 1927

20 UNDERTAKER J. Tracy Hess ADDRESS 518 Eutaw St.

Spec.—1-10-21—M&T—1500 Bks

E 17869

# HEALTH DEPARTMENT—CITY OF BALTIMORE.

46 E 17869

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Woman's Hospital

CITY OF BALTIMORE: (No.) John & Lafayette ST. 14-33 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Addie Florence Burns

(a) RESIDENCE NO. 525 E Dittring ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | married |

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) ~~WIFE of~~ Wife of Laurence A. Burns.

6 DATE OF BIRTH (month, day, and year) Sept 7, 1883

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 43 | 4 | 4 3 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 03

(b) General nature of industry, business, or establishment in which employed (or employer) X

(c) Name of employer X

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER William R. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Annie K. Scherer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Laurence A Burns (Address) 525 E Dittring St

15 Filed JAN 14 1927, 19 — C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 11 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan. 10, 1926, to Jan. 11, 1927,

that I last saw her alive on Jan. 11, 1927,

and that death occurred, on the date stated above, at 1:10 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of ovary with metastases to abdominal viscera

(duration) ~~yrs.~~ 5 mos ~~ds.~~

CONTRIBUTORY (Secondary) Acute dilatation of heart 5 min.

(duration) ~~yrs.~~ ~~mos.~~ ~~ds.~~

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes. Date of Jan. 11, 1927.

Was there an autopsy? No!

What test confirmed diagnosis? Gross Pathology

(Signed) W M Nelson, M. D.

, 19 (Address) Women's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem

DATE OF BURIAL 1/17 1927

20 UNDERTAKER J. F. Fahey & Sons

ADDRESS 1618 Eight

Spec.—12-9 25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17870

## CERTIFICATE OF DEATH.

44 E 17870

1-PLACE OF DEATH 508 Robert St

City of BALTIMORE: (No. 508 Robert St St., 14-20 Ward)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William F Craig

(a) RESIDENCE NO. 508 Robert St St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Addie Craig

6 DATE OF BIRTH (month, day, and year): Oct 15 1869

7 AGE: Years 57 | Months 2 | Days 26 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Waiter

(b) General nature of industry, business, or establishment in which employed (or employer): Hotel

(c) Name of employer

9 BIRTHPLACE (city or town): _____

(State or country) Charles County Md

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town): _____

(State or country) unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town): _____

(State or country) unknown

14 Informant: Mrs Addie Craig

(Address) 508 Robert St

Filed 1-4 1927, 19 C. HAMPSON JONES, M. D.

Per _____ Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 26 1926, to Jan 11, 1927, that I last saw him alive on Jan 11, 1927, and that death occurred, on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) _____

(duration) yrs. mos. ds.

18 Where was disease contracted (if not at place of death) _____

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis? _____

(Signed) H McCauley M. D.

, 19 (Address) 2005 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Date of Burial

Asbury Cemetery Jan 14 1927

20 UNDERTAKER: ADDRESS

Mrs Chas T Bailey 1421 Jeffers St

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17871

## CERTIFICATE OF DEATH.

90 E 17871

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

REGISTERED NO.

City of BALTIMORE: (No. 27-30 St. Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Harriet Bennett

(a) RESIDENCE NO. 701 Sharp & 225 W Hill St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: ~~Female~~

4 Color or Race: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William Bennett

6 DATE OF BIRTH (month, day, and year): ~~Unknown~~ 1886

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 40 | 8 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Joseph Moore

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary ——

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Maryland

14 Informant: Baltimore City Hosp

(Address): Records

15 Filed JAN 14 1927 19

C. HAMPSON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 4 1927

17

I HEREBY CERTIFY, That I attended deceased from January 4 1927 to January 10, 1927, that I last saw him alive on January 10, 1927, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Obesity

Chronic Myocarditis & Insufficiency Aortic Insufficiency (Chron)

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary): Myocardial failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? general & laboratory

(Signed) R. Hampson Jones, M. D.

Jan 14 1926 (Coroner)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem. Date of Burial: Jan 14 1927

20 UNDERTAKER: S. A. Brown & Son ADDRESS: 108 W. Monte

Spec.—1-12-23—M&T—500 Bks.

E 17872 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 11-001 E 17872

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 842 S. Eutaw ST.) 27-31 (WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary M. Garrett

(a) RESIDENCE NO. 842 S. Eutaw ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced. (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: William Garrett

6 DATE OF BIRTH (month, day, and year): — 1873

7 AGE: Years 34 | Months — | Days — | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: ?

9 BIRTHPLACE (city or town) (State or country): Anne Arundel Co. Maryland.

PARENTS

10 NAME OF FATHER: Elwood Major

11 BIRTHPLACE OF FATHER (city or town) (State or country): U.S. Maryland.

12 MAIDEN NAME OF MOTHER: Bettie Lee.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md Co. Maryland.

14 Informant: Annie Travers.
(Address): 804 N. Carolina

Filed JAN 14 1927 HARRY JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/11 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan-4 1927 to Jan-11 1927, that I last saw h alive on Jan-11 1927 and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchopneumonia

(duration) — yrs. — mos 14 ds.

CONTRIBUTORY (Secondary): Influenza?

(duration) — yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? none

(Signed) David Traverse, M. D.

1/11, 1927 (Address) 122 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem. DATE OF BURIAL: Jan 14 1927

20 UNDERTAKER: E. L. Brown & Son ADDRESS: 108 W. Monument

Spec. 1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17873

## CERTIFICATE OF DEATH.

129

E 17873

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 932 Madison Av ST. 11-24 WARD

2-FULL NAME Nellie Williams

(a) RESIDENCE NO. 932 Madison Av ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 46 mos. 2 ds. 5 How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Colored | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carlton Williams

6 DATE OF BIRTH (month, day, and year) Nov 6, 1880

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 46 | 2 | 5 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Abe Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rachel A Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Sidney H Williams Son

(Address) 932 Madison Av

15 Filed JAN 14 1927, 19 C. HAMPTON JONES, M. D. Registrar

Per

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 8, 1926 to Jan 11, 1927.

that I last saw h alive on Jan 11, 1927.

and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Brights (duration) 0 yrs. 6 mos 5 ds.

CONTRIBUTORY (Secondary) Acute Indigestion (duration) 0 yrs. 0 mos. 1 ds.

18 Where was disease contracted if not at place of death? 932 Madison Av

Did an operation precede death? No Date of

Was there an autopsy? No Clinical Symp

What test confirmed diagnosis?

(Signed) R B Kenyon, M. D.

1/8, 19 27 (Address) 1017 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Lawn

DATE OF BURIAL Jan 14 1927

UNDERTAKER Samuel Stemmler

ADDRESS 1128 N Eutaw

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17874 E 17874

## CERTIFICATE OF DEATH.

90

12-50

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2507 St. Paul ST. WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Hayes McMillan

(a) RESIDENCE NO. 2507 St. Paul ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mes. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of ------

6 DATE OF BIRTH (month, day, and year) June 14, 1872

7 AGE — Years: 54 — Months: 6 — Days: 27 — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Head Book-keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Md. Car Wheel Co.

9 BIRTHPLACE (city or town) (State or country): Kansas

PARENTS

10 NAME OF FATHER: Theodore McMillan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ohio

12 MAIDEN NAME OF MOTHER: Abigal Madden

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs. Jeannette W. McMillan

(Address): 2507 St. Paul St.

Received JAN 14 1927 J. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 11 1927

17 I HEREBY CERTIFY, That I attended deceased from January 2, 1927, to January 11, 1927, that I last saw him alive on January 11, 1927 and that death occurred, on the date stated above, at 5:15 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) weeks mos ds.

CONTRIBUTORY (Secondary) Pulmonary Infarction

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical signs

(Signed) W. Kerr M. D.

, 19 (Address) 1734 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemetery

DATE OF BURIAL: 1/14 19 27

UNDERTAKER: Henry U. Weaver & Sons

ADDRESS: Madison

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17875

## CERTIFICATE OF DEATH.

10-001 E 17875

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) Sydenham Hospital St. 3-5 (Ward)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jack Zito

(a) RESIDENCE NO. 44 Albemarle st St., 3 Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 17 mos. 9 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 2nd 1925

7 AGE: Years 1 | Months 4 | Days 10 | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Joseph Zito

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Josephine Scalea

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Frank Catalano
(Address) 44 albemarle st

15 Filed 1-4 1927 C. HARRY JONES M. D. Registrar
Per .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 12 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 3, 1926, to Jan 12, 1927, that I last saw h~~im~~ alive on Jan 12, 1927, and that death occurred, on the date stated above, at 1:30 p m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Tracheotomy Date of 1/10/27

Was there an autopsy? No

What test confirmed diagnosis? Clinical + pos culture

(Signed) Thyrsa S Dulle, M. D

1/13, 1927 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Jan 14 1927

20 UNDERTAKER: Frank V. Valentine — ADDRESS: [illegible] Balto

Spec.—1-10-21 M&T 1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

17876 129 E 17876

PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5021 Park Heights Av. (St.) 27-56 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles H. T. Parke

(a) RESIDENCE No. 5021 Park Heights Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Bessie C. Parke

6 DATE OF BIRTH (month, day, and year) 15 Feb 1885

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 42 | 10 | 28 | |

8 OCCUPATION OF DECEASED Clerk

(a) Trade, profession or particular kind of work At Insurance Co's

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Parke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Nunnegee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Bessie C. Parke (Address) 5021 Park Heights Av

15 Filed JAN 14 1927, 19 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/15/27

17 I HEREBY CERTIFY, That I attended deceased from Dec 7 19 27 to Jan 15 19 27

that I last saw him alive on Jan 12 19 27

and that death occurred, on the date stated above, at 5.15 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis, Arterio-Sclerosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Hypertrophy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Jos. Hirsh M. D.

(Address) 1 W. Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge — DATE OF BURIAL Jan 15 19 27

20 UNDERTAKER Joseph Speakman — ADDRESS 1111 North Av

17877

Keystone H. P. Co.—1000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17877

## CERTIFICATE OF DEATH. 161-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 801 Ellamont ST. WARD 15-67

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Louise Kemp

(a) RESIDENCE. NO. 801 Ellamont ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 11 /27

| 7 AGE Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|
| | | 2 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Irving B. Kemp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick, Md.

12 MAIDEN NAME OF MOTHER Mary A. Woodall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lynchburg Virginia

14 Informant (Address) Irving B. Kemp. 801 Ellamont St.

15 Filed JAN 14 1927 HAMPSON JONES, M.D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 13, 1927

17 I HEREBY CERTIFY, That I attended deceased from January 11, 1927. to January 13, 1927.

that I last saw h e alive on January 13, 1927.

and that death occurred, on the date stated above, at 10:0. m.

The CAUSE OF DEATH* was as follows:

Premature birth

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) congenital debility

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Maurice E. Shamer, M. D.

1-13-1927 (Address) 3300 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Mt. Olivet Cemetery Frederick Md | Jan 14 1927 |

20 UNDERTAKER ADDRESS

Josiah Syfer 1400 W. North Ave

Spec.—12-9-25—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17878

## CERTIFICATE OF DEATH.

185

E 17878

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hosp 12-51 Ward)

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME William Clinors

(a) RESIDENCE NO. 2404 Mare Street Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: mal

4 Color or Race: col

5 Single, Married, Widowed, or Divorced. (write the word): Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 10-1873

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| 54 | | 11 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 087

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Georgia

(State or country)

PARENTS

10 NAME OF FATHER Jeff Clinors

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Georgia

12 MAIDEN NAME OF MOTHER Flora

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Same

14 Informant Mrs. Whitaker

(Address) 2404 Mare St

15 Filed 1 4 1927, 19

C. HARRISON JONES, M. D.

Per Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-10-'27

17 I HEREBY CERTIFY, That I attended deceased from 12-29-'26, to 1-10-'27, 19....., that I last saw him alive on 1-9-'27, 19....., and that death occurred, on the date stated above, at 5 30 a m.

The CAUSE OF DEATH* was as follows:

Cellulitis Rt. leg and Rt. hand and gangrene of left hand. Fever

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Septicemia + pyemia Staphylococcus -

(duration) yrs. mos 5 ds.

18 Where was disease contracted if not at place of death? at home -

Did an operation precede death? yes Date of 12-30-'26

Was there an autopsy? yes -

What test confirmed diagnosis? Pathological findings

(Signed) Wm Johnston, M. D.

, 19 (Address) Balto City Hosp -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Jan 14 1927

20 UNDERTAKER Virginia A. Brooks ADDRESS 1463 Pine

Spec.—6-9-19—H. P. Co.—1000 Bks.

17879

# HEALTH DEPARTMENT—CITY OF BALTIMORE

17879

## CERTIFICATE OF DEATH.

75-001

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2214 Division St. 14-59 (ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Landon

(a) RESIDENCE. No. 2214 Divisionst ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| F | Col | Widowed |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Jan 1 1872

| 7 AGE | Years | Months | Days | If LESS than 1 day, — hrs. or — min. |
|---|---|---|---|---|
| | 55 | | 3 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Private

(c) Name of employer Home

9 BIRTHPLACE (city or town) Queen Anne Co
(State or country) Md

PARENTS

10 NAME OF FATHER James Brown

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mahala Johnson

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Ella Penfield
(Address) 2214 Division St

15 Filed JAN 14 1927 19 C. Hampton Lewis M.D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 12 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 6 1927, to Jan 12 1927, that I last saw h alive on Jan 12 1927, and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. H. McClure, M. D.

1/14 1927 (Address) 1308 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Mt. Auburn | Jan 15 1927 |

20 UNDERTAKER Virginia A. Brooks ADDRESS 1631 Carey St

TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 17880

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17880

Heinrich J. L. Hinrichs

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH So Balt Gen Hos. REGISTERED NO.

City of BALTIMORE: (No. 1213 S. Light St. 24 Ward 33

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Heinrich Hinrichs

(a) RESIDENCE NO. Stepensley Hanover St. Foot of Hull St Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. 14 ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 29, 1868

| 7 AGE Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|
| 58 | 11 | 13 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Fireman 086

(b) General nature of industry, business, or establishment in which employed (or employer): S/S Hunger

(c) Name of employer: North German Lloyd

9 BIRTHPLACE (city or town)

(State or country): Germany

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Not Known

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Not Known

14 Informant: G. Schumacher Jr Bro

(Address): Charles & Redwood Sts.

15 FILED: 1 4 1927 By: C. HANSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Jan 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec. 25 1926, to Jan. 11, 1927, that I last saw h.. alive on Jan 11, 1927, and that death occurred, on the date stated above, at 5:00 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Lobar Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Outboard ship

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. B. Miller, M. D.

1/11, 1927 (Address) So. Balto Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cremation - Loudon Park Cemetery — Date of Burial: Jan 14 1927

20 UNDERTAKER: Henry Sander & Sons Inc — ADDRESS: 1710 Fleet St.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17881

## CERTIFICATE OF DEATH.

177 21-28

E 17881

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Kennedy Ave St____ Ward____)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ernest C Beacham

(a) RESIDENCE NO. 1513 Just St St.____ Ward____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| M. | W | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sing

6 DATE OF BIRTH (month, day, and year) 9/15/1899

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 27 | 3 | 27 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed tor employer) Car Repair

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER John C Beacham

11 BIRTHPLACE OF FATHER (city or town) Norfolk

(State or country)

12 MAIDEN NAME OF MOTHER Bertha Adams

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country)

14 Informant John C Beacham

(Address) 1513 McHenry St

Filed 1927 C. HAMPSON JONES, M. D.

N 14 1927 Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/13 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Blood Poisoning Accidental ?

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) Clarence T Bush M. D.
(Coroner)

, 19 26 (Address) 3375 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Retired Cemetery Date of Burial 1/14/27

20 UNDERTAKER A. Zumsar & Bro ADDRESS 1125 E Baltimore St

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 17882 57 E 17882

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2140 E. Baltimore ST., 6-10 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa King

(a) RESIDENCE NO. 2140 E. Baltimore ST., 6 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 11 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F. | White | Widowed |

5a If ~~married~~, widowed, or ~~divorced~~
~~HUSBAND~~ of
(or) WIFE of James King

6 DATE OF BIRTH (month, day, and year) Feb. 4 1858

| 7 AGE | Years | Months | Days | If LESS than 1 day, .... hrs. or .... min. |
|---|---|---|---|---|
| | 68 | 11 | 24 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Hannibal

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany

14 Informant Robert King
(Address) 2140 E. Baltimore St.

15 Filed JAN 14 1927 C. HAMPSON JONES, M. D. Registrar

Per .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 12 1927

17

I HEREBY CERTIFY, That I attended deceased from March, 1920, to Jan. 12, 1927.

that I last saw her alive on Jan. 11, 1927,

and that death occurred, on the date stated above, at 3:30 A. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 7 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No. Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Urinary

(Signed) Frank A. Glantz M. D.

Jan 13, 1927 (Address) 3244 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Druid Ridge Cem. | 1/14 1927 |
| 20 UNDERTAKER J. A. Moran. | ADDRESS 1000 E. Baltimore St. |

Spec—12-23-21—E.B.R.S.—400 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17883 — 129 — E 17883

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore — Registered No. 27-48

City of BALTIMORE: (No. 4635 York Road, St. ..... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Henry Keller

(a) Residence No. 4635 York Road St., ..... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) ~~WIFE~~ of Arnetta Zinke

6-DATE OF BIRTH (month, day and year) March 9 1857

7-AGE. 69 yrs. 3 mos. 5 4 ds. If LESS than 1 day, ....hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Clerk 009
(b) General nature of industry, business, or establishment in which employed (or employer) Dry Goods Store
(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country). Frederick Md

PARENTS.

10-NAME OF FATHER Chas F Keller

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Frederick Md

12-MAIDEN NAME OF MOTHER. Caroline Hunt

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Frederick Md

14- (Informant) Mrs J Henry Keller
(Address) 4630 York Road Baltimore Md

15- Filed JAN 14 1927 C. HAMPSON JONES, M. D., Registrar. Per .....

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 14, 1927

17- I HEREBY CERTIFY, That I attended deceased from Jan 10, 1927, to Jan 14, 1927, that I last saw her alive on Jan 14, 1927, and that death occurred, on the date stated above, at 1:20 A m.

The CAUSE OF DEATH* was as follows:
Ch Myocarditis
Ch Chronic Nephritis

(Duration) 1+ yrs. mos. ds

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. — mos. — ds

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) S. W. Bishop M. D

Jan 14, 1927 (Address) 3701 Eldorado

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Olivet Frederick Md — DATE OF BURIAL. Jan 17, 1927

20-UNDERTAKER. C Carey — ADDRESS Frederick Md.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17884

## CERTIFICATE OF DEATH.

23-31 90

REGISTERED NO. E 17884

1-PLACE OF DEATH

City of BALTIMORE: (No. 25 E. Hamburg St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vera C. Spangler

(a) RESIDENCE NO. 25 E. Hamburg St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 18. 1918

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 8 | 3 | 25 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolgirl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Charles A. Spangler

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Mary Englart

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto. Md.

14 Informant Mrs. C. Spangler (mother)

(Address) 25 E. Hamburg St.

15 Filed JAN 14 1927 C. HAMPSON JONES M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 13/27 19

17

I HEREBY CERTIFY, That I attended deceased from Oct 12/26, 19..., to Jan 13/27, 19..., that I last saw her alive on Jan 13/27, 19..., and that death occurred, on the date stated above, at 8:30 A.m.

The CAUSE OF DEATH* was as follows:

Acute Dilated Heart

(duration) ...yrs. ...mos. one hour ds.

CONTRIBUTORY Interstitial Nephritis

(Secondary)

Pneumonia (duration) ...yrs. 3 mos. ...ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) H. Bloom M. D.

Jan 13/27 (Address) 1736 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. Date of Burial Jan. 17 1927

20 UNDERTAKER Margaret G. Flynn ADDRESS 1422 Light St.

Sutero

Spec.—6-9-19—H. P. Co.—1000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17885

## CERTIFICATE OF DEATH.

162

E 17885

1-PLACE OF DEATH Franklin Square Hosp

REGISTERED NO.

CITY OF BALTIMORE: (No. 9-13 ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Sutera

(a) RESIDENCE. No. 1042 N. Broadway ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word):

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 12-27.

7 AGE: Years | Months | Days: 1 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country) Franklin Square Hosp.

PARENTS

10 NAME OF FATHER Sam Sutera

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Carmela Filorfe

13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

14 Informant Salvatore Sutero
(Address) 1042 N. Broadway

15 [illegible] C. HAMPSON JONES, M. D.
(Address)

JAN 14 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/13 1927

17 I HEREBY CERTIFY, That I attended deceased from 1/12, 1927, to 1/13, 1927,
that I last saw her alive on , 19 ,
and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Asphyxia Neonatorum

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Franklin Dederick M. D.

, 19 (Address) Franklin Sq Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery | DATE OF BURIAL: 1/14 1927

20 UNDERTAKER: Geo. J. Ruth | ADDRESS: 1735 Harford Ave

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17886

## CERTIFICATE OF DEATH.

49

14-30

REGISTERED No. E 17886

1-PLACE OF DEATH Mercy Hospital

City of BALTIMORE: (No. ____ St. ____ Ward ____)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Ella D. Teal

(a) RESIDENCE NO. 1504 Bolton St. Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ____

6 DATE OF BIRTH (month, day, and year): Sept. 21, 1860

7 AGE: Years 66 | Months 3 | Days 25 | IF LESS than 1 day....hrs. or....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Real Estate

(b) General nature of industry, business, or establishment in which employed (or employer): ____

(c) Name of employer: ____

9 BIRTHPLACE (city or town): Baltimore

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Geo. M. Teal

11 BIRTHPLACE OF FATHER (city or town): ____

(State or country): Baltimore, Md.

12 MAIDEN NAME OF MOTHER: Mary A. Clark

13 BIRTHPLACE OF MOTHER (city or town): ____

(State or country): Baltimore, Md.

14 Informant: Mary A. Sinclair

(Address): 1504 Bolton St.

15 Filed ____, 19____ C. HAMPTON JONES, M.D. Registrar

JAN 14 1927 Per ____

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 13 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 10, 19 26, to Jan 13, 19 27, that I last saw h[illegible] alive on Jan 13, 19 27, and that death occurred, on the date stated above, at 12.45 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Thyroid

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) ____

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? ____

Did an operation precede death? yes Date of Dec 23-26

Was there an autopsy? ____

What test confirmed diagnosis? ____

(Signed) Constantine ____ M.D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem

Date of Burial: 1-15 1927

20 UNDERTAKER: Henry W. Jenkins Sons Co

ADDRESS: Orchard & McCulloh

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17887

## CERTIFICATE OF DEATH

1-001

E 17887

1-PLACE OF DEATH Maryland General Hospital

REGISTERED NO.

CITY OF BALTIMORE: (NO. ..... ST. 1146)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Wm P. Burroughs

(a) RESIDENCE NO. 2106 Auguste ST., ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mrs Wm Burroughs

6 DATE OF BIRTH (month, day, and year) Sept 21 1845

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| 31 | 32 | 3 | 22 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Policeman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St Mary's Co. Md.

PARENTS

10 NAME OF FATHER B Webster Burroughs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Effie Baker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant (Address) Wife 2106 Auguste

15 Filed JAN 14 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 13 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 11 1927 to Jan 13 1927

that I last saw h (w)alive on Jan 13 1927

and that death occurred, on the date stated above, at 6.00 p m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Perforated ulcer - general peritonitis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Wm P Longshore M. D.

1/18, 1927 (Address) 1 W Mulberry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mechanicsville St Marys Co

DATE OF BURIAL Jan 15 1927

UNDERTAKER Henry J Jenkins & Son Co

ADDRESS Oakland Md

Spec.—1-10-21—M&T—1500 Bks.

Coplin

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17888

## CERTIFICATE OF DEATH. 161-001

E 17888

1-PLACE OF DEATH Md. Gen. Hosp.

CITY OF BALTIMORE: (No.) Baby Coplin ST. 15-61 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE NO. 3405 Maria Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years | Months | Days | If LESS than 1 day, hrs or 10 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Simon Coplin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Sherry

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Knoxville Tenn

14 Informant: Simon Coplin

(Address) 3405 Maria Ave

15 Filed 1-14 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-14 1927

17 I HEREBY CERTIFY, That I attended deceased from 1-14 1927 to 1-14 1927

that I last saw her alive on 1-14 1927

and that death occurred, on the date stated above, at 5:20 a. m.

The CAUSE OF DEATH* was as follows: Premature Birth.

Cause unknown.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) Guy A. Thompson M. D.

, 19 (Address) Md. Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rest Lawn

DATE OF BURIAL: Jan 14 1927

UNDERTAKER: H. Levering Bro

ADDRESS: 6 W. Saratoga

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17889

## CERTIFICATE OF DEATH

161-001

E 17889

REGISTERED NO. 13-59

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Woman's Hospital ST. WARD)

2-FULL NAME Baby Schloss

(a) RESIDENCE NO. Duke Drive 4 to ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 14, 1927

| 7 AGE | Years | Months | Days | If LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | | | | 6 |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Howard Schloss

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Louise Levy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Louisiana

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 14 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan. 14, 1927. to Jan. 14, 1927.

that I last saw him alive on Jan 14, 1927

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Atelectasis.

(duration) 6 hours - ds.

CONTRIBUTORY (Secondary) prematurity (7 mos.)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) H. N. Brock, M. D.

, 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

14 Informant (Address) Howard Schloss (father) Duke Drive 4 to Bklyn

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Hebrew Cem. DATE OF BURIAL 1/14/1927

20 UNDERTAKER David Sondheim ADDRESS 615 20 av. cor. Royal Av.

15 Filed 1-14-1927. HAMP. JONES, M. D. Registrar

Cor.—12-9-25—A Co.—200 Bks.

E 17890

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

100-001

770-69

REGISTERED E 17890

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) 531 So. Smallwood St., (Ward)

2-FULL NAME Ruth Naomi Ford

(a) RESIDENCE NO. 531 So. Smallwood Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 23rd 1926

7 AGE: Years — Months — Days 24 20

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto

PARENTS

10 NAME OF FATHER Webster L. Ford

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Missouri

12 MAIDEN NAME OF MOTHER Mary E. Duckett

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto

14 Informant Webster L. Ford

(Address) 531 So. Smallwood St

Filed JAN 14 1927 C. HAMPSON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 13 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Thos. B. Horton M. D. (Coroner)

Jan 13th 1927 (Address) Curtis Bay Md

*State the Disease Causing Death, or if Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the state yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem Date of Burial Jan 14 1927

20 UNDERTAKER Joseph L Cook ADDRESS 1003 Pratt St

Spec.—1-10-21—M&T—1500 Bks.

E 17891

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17891

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH 1404 Bolton

CITY OF BALTIMORE: (NO. 1404 ST. 14-20 WARD) REGISTERED NO. 114

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Maria Watson Miller

(a) RESIDENCE NO. 1404 Bolton ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | W | Widow |

5a If married, widowed, or divorced (01) HUSBAND of (01) WIFE of John Madison Miller

6 DATE OF BIRTH (month, day, and year) Sept 1st 1840

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| ~~Sept~~ 1840 Sept. | 86 | 4 | 11 | 1 da |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Belfast Ireland

PARENTS

10 NAME OF FATHER George Hollins

11 BIRTHPLACE OF FATHER (city or town) (State or country) York England

12 MAIDEN NAME OF MOTHER Lydia Campbell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) George H Miller 1404 Bolton St

15 Filed JAN 14 1927 By C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 12 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1926, to Jany 12, 1927, that I last saw h[illegible] alive on Jany 12, 1927 and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Senile debility

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) Barrett Conner Cutler M. D.

13, 1927 (Address) 1404 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem — DATE OF BURIAL Jan 14 1927

20 UNDERTAKER Joseph D Cook — ADDRESS 1003 W Balto St

Spec.—12-9-25—A Co.—200 Blks.

Staton

E 17892

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17892

## CERTIFICATE OF DEATH.

74-001

18-26

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 423 N Pulaski St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C Tomasin Staton

(a) RESIDENCE NO. 423 N Pulaski St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or WIFE of): Charles C. Staton

6 DATE OF BIRTH (month, day, and year): May 1857

7 AGE: Years 69 (70); Months 8; Days —; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): Housework

(c) Name of employer

9 BIRTHPLACE (city or town): Md.

(State or country)

PARENTS

10 NAME OF FATHER James Hyer

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant: Mrs. C. Staton

(Address) 423 Pogpelton st.

JAN 14 1927

Filed H. HARRISON JONES, M. D.

Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-12-1927

17

I HEREBY CERTIFY, That I attended deceased from May 12th, 1926, to Jan 12th, 1927, that I last saw h[illegible] alive on Jan 12, 1927, and that death occurred, on the date stated above, at 9:50 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Paralysis

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Hypostentium

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) 1063 Hyde ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — Date of Burial 1/14/27

UNDERTAKER: Wm. R. G. Elliott — ADDRESS 425 Eastern ave

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17893

## CERTIFICATE OF DEATH.

31 E 17893

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1104 E Lexington St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Thomas

(a) RESIDENCE NO. 1104 E Baltimore St. Ward

(Usual place of abode) (If non-resident give city or town and state)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. 6/12 mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 Color or Race W C

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 12 1909

7 AGE

| Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|
| 19 | 11 | 30 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER John Thomas

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country)

12 MAIDEN NAME OF MOTHER Rosa Gardner

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country)

14 Informant Julia Brown friend

(Address) 1104 E Lexington

15 Filed JAN 14 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 5, 1926, to Jan 11, 1927, that I last saw h[illegible] alive on Jan 11, 1927, and that death occurred, on the date stated above, at 5 40 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis

(duration) 4 mos. 6 ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) [illegible], M. D.

Jan 13, 1927 (Address) 508 Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Calvary Cem Date of Burial Jan 14 1927

20 UNDERTAKER Mrs N A Elliott ADDRESS 1725 Ashland Ave

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17894

E 17894

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Memorial St., Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Estella Leigh.

(a) RESIDENCE NO. 623 N. Kenwood Ave St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Thomas C. Leigh.

6 DATE OF BIRTH (month, day, and year): 1883

7 AGE: 43 Years | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Penna

(State or country)

PARENTS

10 NAME OF FATHER: David Strawbridge

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Penna

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): ?

14 Informant: Thomas C. Leigh

(Address): 623 N. Kenwood Ave

Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/14 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Fractured L Femur Fall Accidental

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Duff Hamilton Jr. M. D.

Coroner

1/14 1927 (Address) 3692 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Freedom Pa. Date of Burial: Jan. 16 1927

20 UNDERTAKER: Hartenstein Homemaker ADDRESS: Md Line Rd

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17895

90E 17895

## CERTIFICATE OF DEATH.

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Aged Mens Home St., 14-27 Ward)

2-FULL NAME Elbert Causey

(a) RESIDENCE NO. 1400 W. Lexington St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Wht

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 7, 1849

| 7 AGE Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|
| 78 | 7 | 16 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): O/O

(c) Name of employer

9 BIRTHPLACE (city or town) Carroll Co. Md.
(State or country)

PARENTS

10 NAME OF FATHER Henry Causey

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Carroll Co. Md.

12 MAIDEN NAME OF MOTHER R. Stem

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Carroll Co. Md.

14 Informant: Mrs. M. Fossett

(Address) 1400 W. Lexington St.

15 Filed JAN 4 1927 C. HAMPSON JONES, M. D. Registrar

Per _____

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 13 19 27

17 I HEREBY CERTIFY, That I attended deceased from Dec 10 1926 to Jan 13, 1927, that I last saw h... alive on Jan 8, 1927, and that death occurred, on the date stated above, at 3:40 p m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(duration) ...yrs. 18 mos. ...ds.

CONTRIBUTORY (Secondary) Pulm Oedema

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) H. H. Norwood, M. D.

Jan, 19 (Address) 1400 W. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Date of Burial: Jan 6th 1927

20 UNDERTAKER: Geo. J. Smith ADDRESS 653 N. ...

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17896

## CERTIFICATE OF DEATH.

100-001

E 17896

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1464 Woodall ST., 24 WARD) REGISTERED NO. 24-35

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Fogler

(a) RESIDENCE No. 1464 Woodall ST., 24 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Nov 16 1926

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | | 1 | 28 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Edgar H Fogler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Mary F Allen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant: Edgar H Fogler

(Address): 1464 Woodall St

15 JAN 4 1927 19

C. HAMPSON JONES, M. D.

Per _____ Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1-13 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan 11, 1927, to Jan 13, 1927.

that I last saw h[illegible] alive on Jan 12, 1927,

and that death occurred, on the date stated above, at 9 25 A m.

The CAUSE OF DEATH* was as follows:

a. Broncho Pneumonia

Uncomplicated Chronic

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Thos J a Stevens, M. D.

1-13 1927 (Address) 2578 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cem — DATE OF BURIAL: 1-15 1927

20 UNDERTAKER: Ed B Nash — ADDRESS: 1158 N Gay St

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17897

## CERTIFICATE OF DEATH

179 E 17897

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 519 Kirkwood Av St.) 28-63 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Ellen Beebe

(a) RESIDENCE NO. 519 Kirkwood Av St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Walter D.

6 DATE OF BIRTH (month, day, and year) Dec 5 1850

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 76 | 1 | 8 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particolar kind of work None

(b) General natore of indostry, bosiness, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md

PARENTS

10 NAME OF FATHER Mc Kinnon

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Mc Kinnon

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Warren B. Beebe

(Address) 519 Kirkwood Av

15 APR 4 1927 C. HAMPSON JONES, M.D. Registrar

Per APRS

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Jan 13 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 1 1926 to Jan 13 1927

that I last saw h[er] alive on Jan 12 1927

and that death occurred, on the date stated above, at 7-30 a m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos 3 ds.

CONTRIBUTORY Nephritis

(Secondary)

(duration) yrs. 3 mos. ds.

18 Where was disease contracted —

If not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Charles J Wells, M. D.

. 19 (Address) 5242 York Rd Bg

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injory, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Point Cem Md | Date of Burial 4/15 1927

20. UNDERTAKER H. W. Cook | ADDRESS 552 E 8th

Very Important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

(Kahl)

HEALTH DEPARTMENT—CITY OF BALTIMORE

# E 17898

## CERTIFICATE OF DEATH

91-002

E 17898

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1039 Augusta St. 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Anna Kahl

(a) RESIDENCE NO. 1039 Augusta St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. da.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Gus Kahl

6 DATE OF BIRTH (month, day, and year): Jan 27 1847

7 AGE: Years 74 Months 11 Days 20 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER John Seitz

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine Streb

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs W H Wilson

(Address) 1047 N Gilmor St

15 C. HAMPSON JONES, M.D.

Registrar

Per

4 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Jan. 17, 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 6th, 1927, to Jan 14, 1927, that I last saw h. alive on Jan 18, 1927, and that death occurred, on the date stated above, at 1-30 p.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) Years Months Days

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. da.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. Ostheimer M. D.

July 14 19 27 (Address) 1501 E Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — Date of Burial: Jan 17 1927

20 UNDERTAKER: H. Fox Cook — ADDRESS: 702 E Fayette

Very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17899 E 17899

## CERTIFICATE OF DEATH.

60-04

1-PLACE OF DEATH

City of BALTIMORE: (No. 900 Poplar Grove St. 16-67 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine K. Groves

(a) RESIDENCE NO. 900 Poplar Grove St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm Groves

6 DATE OF BIRTH (month, day, and year): Aug. 11, 1863

7 AGE — Years: 63 — Months: 5 — Days: 7 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Harford Co.

(State or country)

PARENTS

10 NAME OF FATHER: Patrick J. Kennedy

11 BIRTHPLACE OF FATHER (city or town): Ireland

(State or country)

12 MAIDEN NAME OF MOTHER: Anna Farrell

13 BIRTHPLACE OF MOTHER (city or town): Ireland.

(State or country)

14 Informant: Mr. Jerome Gatchell

(Address) 900 Poplar Grove St.

15 JAN 4 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: Jan. 13, 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1926, to Jan. 13, 1927, that I last saw her alive on Jan. 12, 1927, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis (Chronic)

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Eyelid Malignancy

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. L. Cassagne, M. D.

Jan. 14, 1927 (Address) 5 & 4 Drury Lane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Long Green Md. Date of Burial: Jan. 15 1927

20 UNDERTAKER: Margaret S. Flynn ADDRESS: 1422 Light St.

Spec.—1-12-23—M&T—500 Bks.

1927 E 17900

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17900

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 7-9 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Allred

(a) RESIDENCE NO. Hazlehurst Ga ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 8 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1871

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 56 | .. | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lumber Business

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ..... (State or country) Ga.

PARENTS

10 NAME OF FATHER A. R. Allred

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Ga

12 MAIDEN NAME OF MOTHER Eliz - Upton

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Ga

14 Informant Reeves.
(Address) JOHNS HOPKINS HOSPITAL

15 Filed 4 1927 C. HAMPSON JONES, M. D.
PM Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 13 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 5 1927 to Jan 13 1927, that I last saw him alive on Jan 13 1927 and that death occurred, on the date stated above, at 5-6 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) ? yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. 3 (history) mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of

Was there an autopsy? yes.

What test confirmed diagnosis? laboratory

(Signed) W. Lindsay Miller, M. D.

1/14/1927 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hazlehurst Ga DATE OF BURIAL Jan 14 1927

20 UNDERTAKER John O. Mitchell ADDRESS 1701 W Fayette St

Spec.–7-17-26–A Co.–200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 17901

REGISTERED NO. 179 E 17901

1-PLACE OF DEATH

City of BALTIMORE: (No. 1822 Riggs Ave. Ward) 16-22

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna C. Rossing

(a) RESIDENCE NO. 1822 Riggs Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 2 mos. — ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel Rossing

6 DATE OF BIRTH (month, day, and year) October 6 1854

| 7 AGE | Years | Months | Days | IF LESS than 1 day ... hrs. or ... min.. |
|---|---|---|---|---|
| | 72 | 3 | 4 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER John B. Hay

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Kiefer

13 BIRTHPLACE OF MOTHER (City or town)

(State or country) Germany

14 Informant Charles Rossing

(Address) 1822 Riggs Ave

15 C. HAMPSON JONES, M. D. Registrar

4 1927 Por

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JAN 13 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1927, to Jan 13, 1927.

that I last saw her alive on " 13, 1927.

and that death occurred, on the date stated above, at 3.50 P m.

The CAUSE OF DEATH* was as follows:

Chron. Nephritis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) — yrs. — mos. 4 ds.

18 Where was disease contracted —

if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Urinary

(Signed) Chas. C. Conner, M. D.

1/14, 1927 (Address) 1011 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — Date of Burial JAN 17 1927 19

20 UNDERTAKER Geo W Little — ADDRESS

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17902

# CERTIFICATE OF DEATH.

E 17902

+178

1-PLACE OF DEATH

REGISTERED NO._____

City of BALTIMORE: (No. Mercy Hospital, St., 4-7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harold J. Cantler.

(a) RESIDENCE NO. Linthicum's Md. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 Color or Race: White.

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, HUSBAND of XXXXXXXXXXXXX: Estelle Cantler.

6 DATE OF BIRTH (month, day, and year): June, -- 1900

7 AGE: Years 26; Months 6; Days --; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Coal trimmer

(b) General nature of industry, business, or establishment in which employed (or employer): B. & O. R. R. Co.

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Delaware.

PARENTS

10 NAME OF FATHER: William F. Cantler.

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Maryland.

12 MAIDEN NAME OF MOTHER: Mary Elliott.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Maryland.

14 Informant: William F. Cantler. (father)

(Address): 117 E. 24th. St.

15 1927 C. HAMPSON JONES, M. D. Registrar

For

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): January 13, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burned about the face and body by an explosion aboard S/S Richelieu.
Pneumonia. Accidental Death.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt M. D.

(Coroner)

1/14 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? B. & O. R. R. Co. pier Curtis Bay Jan. 4, 1927

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Hopkins Co. Date of Burial 1/15 1927

20 UNDERTAKER: Wm Cook ADDRESS 602 E. Pratt

Cor.—12-9-25—A Co.—200 Bks.

E 17903

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

114

E 17903

1-PLACE OF DEATH

City of BALTIMORE: (No. 1016 William St. St. 24-33 Ward)

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ethel L. Phillips.

(a) RESIDENCE NO. 1016 William St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. 4 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female. | White. | Single. |

6a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) August 28, 1918.

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 8 | 4 | 20 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.

(State or country)

PARENTS

10 NAME OF FATHER Louis H. Phillips.

11 BIRTHPLACE OF FATHER (city or town) Baltimore, Md.

(State or country)

12 MAIDEN NAME OF MOTHER Florence Preston.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore, Md.

14 Informant Florence Phillips. (mother)

(Address) 1016 William St.

1927 C. HAMPSON JONES, M. D.

Par ---------- Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 12, 1927 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Gastero Intestinal Indigestion.

Eclampsia.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signature) Otto M. Reinhardt M. D.

(Coroner)

1/14 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... d.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Date of Burial 1/15 1927

20 UNDERTAKER Wm Cook. ADDRESS 502 E York st.

Very Important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17904

## CERTIFICATE OF DEATH

90 E 17904

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 712 S. Luzerne Ave St. 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Ernst

(a) RESIDENCE NO. 712 S. Luzerne Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 16. 1864

7 AGE: Years 62 Months 6 Days 27 26 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 049

(b) General nature of industry, business, or establishment in which employed (or employer): Oyster Shucker

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md.

PARENTS

10 NAME OF FATHER: Herman Ernst

11 BIRTHPLACE OF FATHER (City or town): Balto

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Anna Mutschler

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: Mathilda Ferguson

(Address): 712 S. Luzerne Ave

15 Filed 4 1927 C. HAMPSON JONES, M. D. Registrar

Per NRH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 13 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 10 1927, to Jan 13 1927,

that I last saw h[illegible] alive on Jan 13 1927,

and that death occurred, on the date stated above, at 9 40 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) unknown ds.

CONTRIBUTORY (Secondary) Chronic myocarditis

(duration) yrs. unknown ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Fausto Jannuzzi M. D.

11/14 1927 (Address) 2429 Fait Ave.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| First Evangelical Cemetery | Jan 15. 1927 |
| 20 UNDERTAKER | ADDRESS |
| Henry Sander & Sons Inc | 1710 Fleet St |

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17905

## CERTIFICATE OF DEATH.

74-001

E 17905

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. ____ St., 12-51 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Payne

(a) RESIDENCE NO. 318 West 22½ St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Negro | Married |

5a If married, widowed, or divorced
BUSBAND of
(or) WIFE of Carl Kruse?

6 DATE OF BIRTH (month, day, and year) 1878
Unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 49 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant

(Address) Records

15 Filed C. HAMPSON JONES, M. D. Registrar

5 1927 PM

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 12 1927

17

I HEREBY CERTIFY, That I attended deceased from January 11 1927, to January 12, 1927, that I last saw him alive on January 12, 1927, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Arterial Sclerosis

Hypertension

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? General & Laboratory

(Signed) R Hooper Jones, M. D.

Jan 14 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gloucester Co. Va Date of Burial 1/17/27

20 UNDERTAKER Mrs. N. A. Elliott ADDRESS 1725 Ashland Ave

Very Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 17906

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17906

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 703 Druid Hill Ave ST. 1-24 WARD)

REGISTERED NO. 1-24 100 81

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Saunder

(a) RESIDENCE NO. 703 Druid Hill Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Married

6 DATE OF BIRTH (month, day, and year): May 1905

7 AGE: Years 21 Months 8 Days —

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): N. Carolina

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Minnie Deane

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C

14 Informant George Saunders

(Address)

15 Filed 1-24, 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 13 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 12, 1927, to Jan 13, 1927, that I last saw h[illegible] alive on Jan 12, 1927, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

I Pulmonary Pneumonia

(duration) 2 yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) P. N. Holetus, M. D.

1/14, 1927 (Address) 1715 Pa Ave,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cularda N. C.

DATE OF BURIAL: 1/15/27

20 UNDERTAKER: Mrs. R. A. Elliott

ADDRESS: 1723 Ashland

Spec.—1-10-21—M&T—1500 Blks.

E 17907

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17907

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 208 Vernal ct, ST., 3-D WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Morris

(a) RESIDENCE NO. 208 Vernal ct ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~: Clara Morris

6 DATE OF BIRTH (month, day, and year): Feb 22/1874

7 AGE: Years 52 Months 10 Days 20 21 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer with Co.

(b) General nature of industry, business, or establishment in which employed (or employer): Contractors

(c) Name of employer: Glendenning Bros

9 BIRTHPLACE (city or town) (State or country): Washington D.C.

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not Known

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Clara Morris

(Address): 208 Vernal ct

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

5 1927 RPH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 12/1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 5 . 1927 . to Jan 12/ . 1927.

that I last saw h~~er~~ alive on Jan 11 . 1927 .

and that death occurred, on the date stated above, at 3.45 P.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. 1 mos 4 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No ~~Date of~~

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) Richard C Cunningham M. D.

. 19 (Address) 1514 Walbrook Balto md

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: 1/15/27

20 UNDERTAKER: Mrs. R. A. Elliott — ADDRESS: 1729 Ashland av

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17908

## CERTIFICATE OF DEATH.

31 E 17908

1-PLACE OF DEATH 149- calvin H. 5-8

City of BALTIMORE: (No. Bruce Hudgins St. Ward)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bruce Hudgins

(a) RESIDENCE NO. 149- calvin St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: col

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3-2-1905

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 21 | 10 | 10 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Do

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country)

PARENTS

10 NAME OF FATHER Richards Hudgins

11 BIRTHPLACE OF FATHER (city or town) Va

(State or country)

12 MAIDEN NAME OF MOTHER Cornelius Evans

13 BIRTHPLACE OF MOTHER (city or town) Va

(State or country)

14 Informant Mrs. R. G. Elliott

(Address) 1325 Ashland av

15 _____, 19 _____ Registrar

5 1927

Burr

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-12- 1927

17 I HEREBY CERTIFY, That I attended deceased from 1-10-, 1927, to 1-12-, 1927,

that I last saw h[illegible] alive on 1-12-, 1927,

and that death occurred, on the date stated above, at 5.25 p.m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

from Hurting about (duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death!

Did an operation precede death! Date of

Was there an autopsy! no

What test confirmed diagnosis? Clinical

(Signed) C. L. Jackson, M. D.

1/13 1927 (Address) 1809 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvary Cem. Date of Burial 1/16/27

20 UNDERTAKER: Mrs. R. G. Elliott ADDRESS 1325 Ashland av

Very Important. See Instructions on back of Certificate.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17909

## CERTIFICATE OF DEATH.

E 17909

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Baltimore General Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Donald Poffner

(a) RESIDENCE NO. 526-W Biddle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 10/31/1918

7 AGE: Years 8 Months 3 Days 13 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED:

(a) Trade, profession or particular kind of work: School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS'

10 NAME OF FATHER: Lawrence Poffner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Josephine Cole

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mrs. Poffner (Address) Mercy Baltimore Gen. Hospital

Filed JAN 5 1927 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/14/1927

17 I HEREBY CERTIFY, That I attended deceased from 1/22 1927 to 1/14 1927

that I last saw her alive on 1/14 1927

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

acute endocarditis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Acute appendicitis

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 1/13/27

Was there an autopsy? yes

What test confirmed diagnosis? Clinical history

(Signed) Howard L. Jenkins M. D.

1/14 1927 (Address) Mercy Baltimore Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Auburn

DATE OF BURIAL: 1/18/27

20 UNDERTAKER: Wm. R. G. Elliott

ADDRESS: 1722 Eutaw Pl.

Spec.—1-10-21—M&T—1500 Bks.

E 17910

# HEALTH DEPARTMENT—CITY OF BALTIMORE E 17910

## CERTIFICATE OF DEATH.

12-51 129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 602 N. 33 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emanuel Sheffer

(a) RESIDENCE No. 602 N. 33 ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or WIFE of): Leah Sheffer

6 DATE OF BIRTH (month, day, and year): Oct 25 1847

7 AGE: Years 79 Months 2 Days 14 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pa

PARENTS

10 NAME OF FATHER: John Sheffer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Susana Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant (Address): Mrs. Rose 602 N. 33 St

5 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 12 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 1st 1926 to Jan 12 1927.

that I last saw h— alive on Jan 11th 1927.

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis & arterio-sclerosis,

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Isaac Sherwood M. D.

1/14 1927 (Address) 846 W 36th St Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge

DATE OF BURIAL: Jan 18 1927

20 UNDERTAKER: R. S. Marshall

ADDRESS: 3539 Fallsway

Spec.—1-10-21—M&T—1500 Bks.

E 17911 HEALTH DEPARTMENT—CITY OF BALTIMORE E 17911

# CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 531 Central Ave ST. 5 WARD 16-08)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorris Vivian Austin

(a) RESIDENCE NO. 531 Central Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): premature infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 11-27

7 AGE Years Months Days: 3 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Samuel Austin

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. C.

12 MAIDEN NAME OF MOTHER: Theresa George

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Theresa Austin

(Address)

15 5 1927 C. HAMPSON JONES, M. D. Registrar

Per —

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14-1927

17

I HEREBY CERTIFY, That I attended deceased from Jan 11- , 1927 , to Jan 14- , 1927 .

that I last saw h[illegible] alive on Jan 13- , 1927 ,

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows: Premature birth (6 months) or (5½ months)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. F. Coleman M. D.

Jan , 19 (Address) 2039 McCulloh

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cem. DATE OF BURIAL: Jan 11 1927

20 UNDERTAKER: Wm J. G. Locks ADDRESS: 1302 Hoffman

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17912 E 17912

## CERTIFICATE OF DEATH.

REGISTERED NO. 89

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 702 S. Sixth ST. 26-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Hogg, Jr.

(a) RESIDENCE NO. 702 S. Sixth ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Hogg.

6 DATE OF BIRTH (month, day, and year) June 1-1882.

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 44 | 7 | 14 | 13 |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Grocery

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Washington, D. C.

PARENTS

10 NAME OF FATHER Wm. H. Hogg. Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Alice Harsha

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Morgan Co. Pa.

14 Informant Emma Hogg. (Address) 702 S. Sixth St

15 Filed 5 1927 C. HAMPSON JONES, M. D. Registrar By R K C

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 13, 1927, to Jan 14, 1927.

that I last saw him alive on " 13, 1927

and that death occurred, on the date stated above, at 10 30 A. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Chas. P. Heer M. D.

1/15/27 (Address) 4085 Pat Pk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn Cemetery — DATE OF BURIAL Jan. 18 1927

20 UNDERTAKER Zirkler + Zirkler — ADDRESS 1739 E. Eager St

Spec.—1-12-23—M&T—500 Blks.

E 17913

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17913

## CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH Mrs Hope Retreat 7-13

CITY OF BALTIMORE: (No. ..... ST., ..... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME (Mrs) Rose Morton

(a) RESIDENCE NO. 2054 E Eager ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 55 yrs. ... mos. ... ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Patrick Morton

6 DATE OF BIRTH (month, day, and year) August 21-1855

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or ... min. |
|---|---|---|---|---|
| | 71 | 4 | 13 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Terrance Rogers.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Hope Reeves.
(Address) Mrs Hope Retreat

15 Filed JAN 15 1927 C. HAMPSON JONES, M. D.
By ..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 13 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 6, 1926, to Jan 13, 1927.

that I last saw h alive on Jan 13, 1927

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(Arteri-sclerosis. Chr Myocarditis)

(duration) yrs. ... mos 3 ds.

CONTRIBUTORY (Secondary) Senile Dementia

Uraemia (duration) 1 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Walter P. Dell, M. D.

, 19 (Address) Mrs Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem.

DATE OF BURIAL Jan 18 1927

20 UNDERTAKER Zirkler & Zirkler

ADDRESS 1739 E. Eager St

Spec.—8-24-14—M. & T.—2000 Bks.

E 17914

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17914

## CERTIFICATE OF DEATH.

44 J

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 225 London STREET) (WARD) 40-11

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Clements

(Residence in Baltimore: No. 225 London ave ... 7 yrs., mos. da.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE. W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widow

6-DATE OF BIRTH. No. ... (Month) ... (Day) 1851 (Year)

7-AGE. 75 yrs. ... mos. ... da.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ... No.
(b) General nature of industry, business, or establishment in which employed (or employer) ...

9-BIRTHPLACE, (State or Country), Liethvania

PARENTS.

10-NAME OF FATHER, Vincent Sastaskeu

11-BIRTHPLACE OF FATHER (State or Country), Lithvania

12-MAIDEN NAME OF MOTHER No.

13-BIRTHPLACE OF MOTHER (State or Country), Lithvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Victorea Armen

(Address) 225 Loudon Ave

15-

Filed 5 1927 By C. HAMPSON JONES, M. D. Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. January 14, 1927.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 2, 1926, to January 14 1927, that I saw h er alive on January 13 1927, and that death occurred, on the date stated above, at 6 40 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of the liver

(Duration) 4 yrs. mos. da.

CONTRIBUTORY (Secondary) Chronic Valvular Heart Dis

(Duration) yrs. 6 mos. da.

(Signed) John A. Skendzonskas M. D.

Jan. 14. 1927 (Address) 648 Washington Blvd.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... da. In the State ... yrs. ... mos. ... da.

Where was disease contracted, if not at place of death? ...

Former or usual residence 225 London ave.

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Jan. 17. 1927

20-UNDERTAKER John Grebliauckas J.G. — ADDRESS 423 S Paca St.

Spec. 6-9-19—H. P. Co.—1000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17915 E 17915

## CERTIFICATE OF DEATH.

REGISTERED NO. 57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 612 N. Milliman ST.) (WARD) 7-10

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Weber

(a) RESIDENCE. NO. 612 N. Milliman ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wife

6 DATE OF BIRTH (month, day, and year): July 2 1866

7 AGE: Years 60 Months 6 Days 21 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Peter Lindemann

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant: Mrs. Selma Moyer

(Address) 612 N. Milliman ave

15 1927 C. HAMPSON JONES, M. D.

Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 16 1927

17 I HEREBY CERTIFY, THAT I attended deceased from Dec 1 1926 to Jan 16 1927

that I last saw h alive on Jan 14 1927

and that death occurred, on the date stated above, at 6 A M

The CAUSE OF DEATH* was as follows: Diffuse Peritonitis, Septicemia, Diabetes, Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. Hampson Jones M. D.

Jan 16 1927 (Address) 600 N. Milliman Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — DATE OF BURIAL: Jan 16 1927

20 UNDERTAKER: Schumacher & Caroles — ADDRESS: 1004 Lexington st

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 17916

1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

E 17916

REGISTERED NO.

City of BALTIMORE: (No. 1030 W. Lexington St., 18-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Arthur Womack

(a) RESIDENCE NO. 1030 W. Lexington St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | col | Divorced |

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Annie Womack

6 DATE OF BIRTH (month, day, and year) 3-2-1895

| 7 AGE Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|
| 31 | 10 | 10 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer (Day)

(b) General nature of industry, business, or establishment in which employed (or employer) Concrete work

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Va.

PARENTS

10 NAME OF FATHER Fred Womack

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Annie Hazelwood

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Mrs. Womack

(Address) 1020 W Lexington

15 Filed 1 5 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

1-12-27

17 I HEREBY CERTIFY, That I attended deceased from 1/9/ 19 27, to 1/12/ 19 27, that I last saw him alive on 1/11/ 19 27, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Acute dilatation of heart (duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

Signed) L. C. Jackson, M. D.

1/12, 1927 (Address) 808 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Date of Burial Jan 15 1927 19

20 UNDERTAKER James Eaton ADDRESS 916 Cathedral

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE E 17917

E 17917

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mary E. Stewart 1-24 WARD)

2-FULL NAME 778 St. Mary's Ave, W. St. Mary's

(a) RESIDENCE NO. (Usual place of abode) Same ST WARD

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? (If non-resident give city or town and State) yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): 1851

7 AGE: Years 76 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto City

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Bettie F. Browne 778 St. Mary's Ave

15 C. HAMPSON JONES, M. D. Registrar

5 1927

19 ... Per BHH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 15th 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 9th, 19 26, to Jan. 14th 19 27

that I last saw h[e] alive on 1/13/27

and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Obstruction of Age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) R. Lee Christ, M. D.

(Address) 824 Monroe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn DATE OF BURIAL Jan 15-1927

20 UNDERTAKER: Wilson Eastern ADDRESS 916 Mc

TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17918

## CERTIFICATE OF DEATH.

90 E 17918

1-PLACE OF DEATH

City of BALTIMORE: (No. ____ St., 713 Ward)

REGISTERED NO. ____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Wells

(a) RESIDENCE NO. 703 N. Dallas St. ____ Ward ____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ____ mos. ____ ds. How long in U. S., If of foreign birth? ____ yrs. ____ mos. ____ ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1870

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 57 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Waiter 070

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Maryland

PARENTS

10 NAME OF FATHER Charles Wells

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Maryland

12 MAIDEN NAME OF MOTHER Emma —

13 BIRTHPLACE OF MOTHER (city or town): Baltimore

(State or country): Maryland

14 Informant:

(Address): Records

15 Filed 5 1927 — C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 11 1927

17 I HEREBY CERTIFY, That I attended deceased from December 24 1926, to January 11, 1927, that I last saw him alive on January 11, 1927, and that death occurred, on the date stated above, at 7.15 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

Antecedent Sclerosis

Chronic Myocarditis & Emphysema

(duration) ....yrs. 2 mos. 3 ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) ....yrs. .... mos. 1 ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? general & Laboratory

(Signed) C. Hampson Jones, M. D.

Jan 11 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery Date of Burial: Jan 16 1927

20 UNDERTAKER: Mrs Chas G. Baily ADDRESS: 1121 Jefferson

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17919 E 17919

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5309 Magnolia Ave ST. 27-55 118 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie Blackwith

(a) RESIDENCE NO. 5309 Magnolia Ave ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 50 yrs. ... mos. ... ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J. M. Blackwith

6 DATE OF BIRTH (month, day, and year) April 5, 1854

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs or ..... min. |
|---|---|---|---|---|
| | 72 | 8 | 10 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Fritz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Bertha Schroder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Chas. Schaefer
(Address) 1732 Mansfield Ave

15 Filed JAN 17 1927, 19 Per ..... Registrar C. HAMPSON JONES, M. D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 13, 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 11, 1927 to Jan. 13, 1927.

that I last saw he alive on Jan 13, 1927.

and that death occurred, on the date stated above, at 3:15 P m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. ... mos 3 ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. ... mos. 1/2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) H. B. Thurn M. D.

1-17, 1927 (Address) 21 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Druid Park Cemetery | Jan 15, 1927 |
| 20 UNDERTAKER H. O. Wyatt 1-50. | ADDRESS [illegible] |

CAUSE OF DEATH must be filled in plainly, so that it may be properly classified. PARTICULAR ATTENTION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17920

## CERTIFICATE OF DEATH.

90 E 17920

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 1215 N. Eden St St. 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Grover

(a) RESIDENCE NO. 1215 N. Eden St St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of XXXXXX

6 DATE OF BIRTH (month, day, and year)

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | about 70 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Advertising do

(b) General nature of industry, business, or establishment in which employed (or employer) Agent

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country)

14 Informant Kennith Winebrenner

(Address) 1215 N. Eden St

15 Date 5 1927 Filed _____ Registrar C. HAMPSON JONES, M. D.

very important. See instructions on back of certificate.

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 13/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Probably Myocarditis

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) _____

(duration) .....yrs. .....mos. .....ds.

(Signed) J. C. Wilson, M. D. (Coroner)

1/15/27 (Address) 500 E. north Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Date of Burial Jan. 15 1927

20 UNDERTAKER Richard F. Cluley ADDRESS 1008 N. B'Way

Spec.—1-12-23—M&T—500 Blks.

Marlborough Apts:- Eutaw Place & Wilson Sts.

E 17921

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17921

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 94

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Marlborough Apts. 4 F. St. 14-22 WARD)

2-FULL NAME May Lowenthal Herzberg

(a) RESIDENCE NO. Marlborough Apts. 4 F. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Sol Herzberg.

6 DATE OF BIRTH (month, day, and year) Dec. 2nd. 1876

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 50 | 1 | 12 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Sol Lowenthal

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Rachel Greensfelder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant (Address) Mr. Sol Herzberg, Marlborough Apts. 4 F.

Filed 1927 C. HAMPSON JONES, M. D. Registrar

By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany. 14th. 1927.

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1926. to January 14th. 1927.

that I last saw her alive on Jan. 14 1927

and that death occurred, on the date stated above, at 3.15 P m.

The CAUSE OF DEATH* was as follows:

Streptococcus. septicemia (viridens)

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) cerebral embolism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? no Date of /

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J Frederick Lesh, M. D.

1-15, 1927 (Address) Temple Garden Apts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Baltimore Hebrew Cemetery | 1/16/ 1927 |

20 UNDERTAKER David Sondheim

ADDRESS 118-20 W. Royal Ave

Spec.—1-12,23-M&T—500 Bks.

E,19 17922

# HEALTH DEPARTMENT—CITY OF BALTIMORE

40 E 17922

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (NO. ..... ST. 12-19 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Oliver

(a) RESIDENCE NO. 202 - 20th ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | col. | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Oliver.

6 DATE OF BIRTH (month, day, and year) 1897

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 30 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER John Oliver

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Rebecca Oliver

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Records.
(Address) JOHNS HOPKINS HOSPITAL

15 Filed JAN 15 1927 19 C. HAMPSON JONES, M. D. Registrar
Per .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 8 1927 to Jan 11 1927

that I last saw h[illegible] alive on Jan 11 1927 at 1.40 P.M.

and that death occurred, on the date stated above, at 1.42 m.

The CAUSE OF DEATH* was as follows:

Acute Urinary retention
with cerebral hemorrhage

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of Jan 9 1927

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Geo. Schacht, M. D.

(Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Richmond Va | Jan 15 1927 |

20 UNDERTAKER Thos. N. Dennis per T. E. Kelson

ADDRESS 130 Preston

Spec.—1-12-23—M&T—500 Blks.

E 17923

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

B 17923

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1608 Darley Ave. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Vera Johnson.

(a) RESIDENCE NO. 1608 Darley Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 9 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female. | white | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4-9-1925

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 1 | 9 | 5 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Wm. A. Johnson.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Emma Tilmyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mr. Wm. A Johnson.
(Address) 1608 Darley

15 5 1927 C. HAMPSON JONES, M. D. Registrar
Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-14- 1927

17 I HEREBY CERTIFY, That I attended deceased from 1-9-, 1927, to 1-14-, 1927

that I last saw h[illegible] alive on 1-14-, 1927

and that death occurred, on the date stated above, at 12 Noon m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) 1 yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. Hampson Jones M. D.

, 19 (Address) 1608 Darley

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Cedar Hill Cem | 1/15 1927 |
| 20 UNDERTAKER | ADDRESS |
| I. Frew McCully | 130 E Fay |

Spec.—1-12-23—M&T—500 Bks.

17924 HEALTH DEPARTMENT—CITY OF BALTIMORE 17924

# CERTIFICATE OF DEATH.

86-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 622 Scott ST. 21-29 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dora A Johnson

(a) RESIDENCE NO. 622 Scott ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs 5 mos. 30 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | W | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 15 1926

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | | 5 | 30 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Norman L Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hawkinsville Ga

12 MAIDEN NAME OF MOTHER Anna V Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mr Norman L Johnson
(Address) 622 Scott St Balto Md

15 Filed Jan 15 1927 C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Jany 10, 1927, to Jan 14, 1927, that I last saw her alive on Jan 13, 1927, and that death occurred, on the date stated above, at 7½ A m.

The CAUSE OF DEATH* was as follows:

Simple Melancholia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? NO Date of —

Was there an autopsy? — NO —

What test confirmed diagnosis? Clinical

(Signed) M. Spiringer M. D.

1/14 1927 (Address) 622 Wolfe St Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mackey Church Cemetery — DATE OF BURIAL Jan 16 1927

20 UNDERTAKER John F Deany — ADDRESS 715 Light St

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17925

122-002

## CERTIFICATE OF DEATH.

E 17925

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 208 E Montgomery ST. 77-33 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie B Otter

(a) RESIDENCE NO. 208 E Montgomery, WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 8 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: August Otter

6 DATE OF BIRTH (month, day, and year): April 6 1855

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 71 | 8 | 7 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Baltimore

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: John G. Fickenscher

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Barbra Seitz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Elizabeth Otter

(Address) 208 E Montgomery st

15 Filed JAN 15 1927 C. HAMPSON JONES, M. D. Registrar

Per RRD

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 13 1927

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1926, to Jan 13, 1927,

that I last saw h[illegible] alive on Jan 12 1927,

and that death occurred, on the date stated above, at 4:35 A m.

The CAUSE OF DEATH* was as follows: Tuberculosis of Pharynx and Visceral.

CONTRIBUTORY (Secondary) (duration) 1 yrs. 6 mos ds. Pulmonary Edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J Work M. D.

1/13. 1927 (Address) 4132 Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery

DATE OF BURIAL: JAN 15 1927

20 UNDERTAKER: John F. Denny

ADDRESS: 715 LIGHT ST

TION IS very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

E 17926

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 17926

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. 16-39 St., 90 Ward)

2-FULL NAME Joseph Lang

(a) RESIDENCE NO. 3616 E. Fayette St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | ? |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1857

| 7 AGE | Years | Months | Days. | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 70 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Messenger

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER George Lang

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER — Shamberger

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant

(Address) Records

15 Filed 5 1927 C. HAMPSON JONES, M. D. Registrar

Per [illegible]

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 12 1927

17

I HEREBY CERTIFY, That I attended deceased from May 10, 1926, to January 12, 1927, that I last saw him alive on January 11, 1927, and that death occurred, on the date stated above, at 6 4 m.

The CAUSE OF DEATH* was as follows:

Senility

Cerebral Sclerosis

Chronic Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? general & Laboratory

(Signed) R. Hooper Smith, M. D.

Jan 12 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Mt. Carmel Cem. Jan. 15 1927

26 UNDERTAKER — ADDRESS

Libby & Zulick 403 S. Wolfe St.

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

1926 43
E 17927

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17927

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST. 6-10 WARD) 10

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Hand

(a) RESIDENCE NO. 111 N. Rose ST., City WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 12 1925

7 AGE — Years: 1 — Months: 11 — Days: 1 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child 500

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md -

PARENTS

10 NAME OF FATHER: Gilbert - Hand

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Anna Campbell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant: Parents
(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar
1827 AKB

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 13 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 1927 to Jan 13 1927, that I last saw him alive on Jan 13 1927, and that death occurred, on the date stated above, at 3 15 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia, lobar

(duration) ..... yrs. ..... mos. 13 ds.

CONTRIBUTORY (Secondary): Cerebral thrombosis

(duration) ..... yrs. ..... mos. 13 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? ..... Date of .....

Was there an autopsy? Brain only.

What test confirmed diagnosis?

(Signed) Harry W. Cornwell M.D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem. — DATE OF BURIAL: Jan. 15 1927

20 UNDERTAKER: Lilly and Zeiler — ADDRESS: 403 S. Wolfe St.

Spec.–7-17-26—A Co.—200 Bks.

E 17928

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 17928

1-PLACE OF DEATH University Hospital REGISTERED NO. 117

City of BALTIMORE: (No. 4-30 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Claiborne

(a) RESIDENCE NO. 31 Kingship Road St. Dundalk Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 22, 1898

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..hrs. or ..mia.. |
|---|---|---|---|---|
| | 28 | | 18 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Crane operator

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER Geo. M. Claiborne

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Nannie Eubank

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant Robert E Claiborne

(Address) 31 Kingship Rd Dundalk

15 Filed JAN 5 1927 C. HAMPSON JONES, M. D. Registrar

By —

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/15/27

17 I HEREBY CERTIFY, That I attended deceased from 1/12/27, 19.., to 1/15/27, 19..,

that I last saw him alive on 1/14/27, 19..,

and that death occurred, on the date stated above, at 2.55 a. m.

The CAUSE OF DEATH* was as follows:

Diffuse Peritonitis

(duration) .. yrs. .. mos. 1 da.

CONTRIBUTORY (Secondary) Perforated Appendix

(duration) .. yrs. .. mos. 4 da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? yes Date of 1/13/27

Was there an autopsy? no

What test confirmed diagnosis? operation

(Signed) J. S. Winstead, M. D.

, 19.. (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Amherst Virginia — Date of Burial Jan 15 1927

20 UNDERTAKER George J Smith — ADDRESS 1532 Hollins St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 17929

# HEALTH DEPARTMENT—CITY OF BALTIMORE E 17929

## CERTIFICATE OF DEATH.

× 96-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ~~Md Balto Gen'l Hospital~~ 10-14 St.) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Colvin Lanier

(a) RESIDENCE NO. Woodlawn Md ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced (a) HUSBAND of (b) WIFE of

6 DATE OF BIRTH (month, day, and year): April 27 1926

7 AGE — Years: — Months: 8 Days: 17 18 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Alexis Lanier

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Lora Loges

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Md Balto Gen. Hospital Rayner & Dukeland Aves.

FILED NOV 5 1927 C. HAMPSON JONES, M. D. Registrar Per ARS

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/14 1927

17 I HEREBY CERTIFY, That I attended deceased from 11/11 1927 to 11/14 1927, that I last saw him alive on 11/14 1927 and that death occurred, on the date stated above, at 10:25 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis.

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary): Lobar pneumonia, Streptococcus

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 11/11/27

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Autopsy

(Signed) Arnold L. Jansen, M. D.

11/14, 1927 Address Md Balto Gen'l Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olive Cemetery (Roslyn)

DATE OF BURIAL: Nov 17 1927

20 UNDERTAKER: Joseph B. Cook

ADDRESS: 603 N. Gay St.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17930

## CERTIFICATE OF DEATH.

31 E 17930

REGISTERED NO. 30-69

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 512 S. Smallwood ST. WARD)

2-FULL NAME Elsie M. Richardson

(a) RESIDENCE No. 512 S. Smallwood St ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 16, 1898

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| 28 | 29 | 6 | 16 26 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work 010

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Albert E. Richardson

11 BIRTHPLACE OF FATHER (city or town) Martinberg
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Agnes Cavey

13 BIRTHPLACE OF MOTHER (City or town)
(State or country) Howard Co., Marvland

14 Informant Albert E. Richardson
(Address) 512 S. Smallwood St.

15 1927 Filed C. HAMPSON JONES, M. D. Registrar
Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 12 1927

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1926, to Jan 12, 1927,
that I last saw h alive on Jan 12, 1927
and that death occurred, on the date stated above, at 10.45p. m.
The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 8 mos. 9 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical + Bacteriological Exam

(Signed) James N. Lazenberg M. D.

Jan. 13 27 (Address) 1729 W. Lombard St.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Loudon Park Cemetery | Jan. 15 1927 |

20 UNDERTAKER Joseph B Cook ADDRESS 1003 W. Balto St

THIS IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.—1-12 23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17931

CERTIFICATE OF DEATH.

E 17931

1-PLACE OF DEATH St Josephs Hospital

CITY OF BALTIMORE: (No. Caroline & Oliver ST. 20-10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Anna T. Rothenhoefer

(a) RESIDENCE No. 3784 Morley. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime (If non-resident give city or town and State)

ds. How long in U. S., If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | white | Married |

5a If married, widowed, or divorced HUSBAND of or) WIFE of Charles G. Rothenhoefer

6 DATE OF BIRTH (month, day, and year) Sept - 1884

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 43 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) P

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md. (State or country)

PARENTS

10 NAME OF FATHER Patrick V. Delaney

11 BIRTHPLACE OF FATHER (city or town) Baltimore md. (State or country)

12 MAIDEN NAME OF MOTHER Jennie Moorwood.

13 BIRTHPLACE OF MOTHER (city or town) Maryland (State or country)

14 Informant Chas G. Rothenhoefer

(Address) 3784 Morley ST

15 Filed JAN 5 1927 C. HAMPSON JONES, M. D. Registrar

Par

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 13 1927

17

I HEREBY CERTIFY, That I attended deceased from 12/7/26, 1926, to 1/13/27, 1927, that I last saw h alive on 1/13/27, 1927 and that death occurred, on the date stated above, at 8.40 p. m.

The CAUSE OF DEATH* was as follows:

generalized Adenocarcinomatosis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchial pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 12/7/26

Was there an autopsy? No operation

What test confirmed diagnosis? Clinical

(Signed) H. K. McCarrell, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery DATE OF BURIAL 1/17/1927

20 UNDERTAKER Chas P. Maus & Son ADDRESS 1181 W. Royal Ave

Spec.–7-17-26—A Co.—200 Bks.

Litz

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17932

## CERTIFICATE OF DEATH

161-001

E 17932

REGISTERED NO. 23-31

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hosp. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane Catherine Litz

(a) RESIDENCE NO. 1226 Hanover St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | white | infant. |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: infant.

6 DATE OF BIRTH (month, day, and year): Jan. 11, 1927

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min.. |
|---|---|---|---|---|
| | | | 2½ days | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: infant. NO

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md.

PARENTS

10 NAME OF FATHER: Elmer Litz

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Lula Glossman

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Md.

14 Informant: Hosp Rec

(Address)

15 Filed 1927 19 C. HARRISON JONES, M. D. Registrar

For

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: Jan. 14, 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 12, 1927, to Jan. 14, 1927, that I last saw h[illegible] alive on Jan. 13, 1927, and that death occurred, on the date stated above, at 8:30 A. m.

The CAUSE OF DEATH* was as follows: (1 week)

Pneumonia (Int. 2-wk. Inf.)

(duration) yrs. mos. 1 wk. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Elmer Louis Diamond M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — Date of Burial: Jan. 15 1927

20 UNDERTAKER: Margaret J. Flynn — ADDRESS: 1422 Light St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—3500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17933

## CERTIFICATE OF DEATH.

101-001

E 17933

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 409 N. Bouldin ST. 76-2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Muller

(a) RESIDENCE NO. 409 N. Bouldin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | white | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 11/29/26

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | | 1 | 15/16 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Laurence Muller

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Y.

12 MAIDEN NAME OF MOTHER Mary C Bailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mr L Muller

(Address) 409 N Bouldin

15 JAN 15 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec. 24 .1927. to Jan. 14 .1927.

that I last saw her alive on Jan 14 .1927

and that death occurred, on the date stated above, at 1P m.

The CAUSE OF DEATH* was as follows:

1 Lobar Pneumonia

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum Examination

(Signed) J Edward Norris M. D.

1.15 .1927 (Address) 107 East West St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Holy Redeemer | 1/15/27 |
| 20 UNDERTAKER | ADDRESS |
| J J Fahey & Sons | 1318 Light St |

CAUSE OF DEATH in plain terms, so that it may be properly classified. Name of disease alone is not sufficient. See instructions on back of certificates. TION is very important.

Fanny Jones.

17934

E 17934

# HEALTH DEPARTMENT---CITY OF BALTIMORE

## CERTIFICATE OF DEATH

90 E 17934

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 894 Lyons st S. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fanny Jones

(Residence in Baltimore: No. 894 Lyons st St.; yrs. mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: Col

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Mard

6-DATE OF BIRTH: Unknown (Month) (Day), 1873 (Year)

7-AGE: 54 53 yrs. mos. ds. If LESS than 1 day, hrs., or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Housedutes
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Md

PARENTS

10-NAME OF FATHER: Geo Grey

11-BIRTHPLACE OF FATHER (State or country): Md

12-MAIDEN NAME OF MOTHER: Hann Robinson

13-BIRTHPLACE OF MOTHER (State or country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jos. Jones

(Address) 894 Lyons St

15-

Filed JAN 16 1927 191 Per

C. HAMPSON JONES, M. D.
REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: 1 (Month) 15 (Day) 1927 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 9-13, 1926, to, 1-15- 1927 that I saw h[illegible] alive on Jan 14 1927 and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(Duration) yrs Don't know mos

Contributory (SECONDARY) Rheumatism

(Duration) yrs Don't know mos

(Signed), H H Goodrich M D

1-15 1927 [Address] 117 W. Lanvale

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Benson Md DATE OF BURIAL: Jany 19 1927

20-UNDERTAKER: Dean & Foster ADDRESS: Bel Air Md

TION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

E 17935

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

13 E 17935

93-59

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Brownstein

(a) RESIDENCE NO. 2114 Brookfield Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ellis Brownstein

6 DATE OF BIRTH (month, day, and year) autumn

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 53 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER Samuel Cohen

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Untaim

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Ellis Brownstein

(Address) 2114 Brookfield Ave

Filed ... 19 ... HARRY S. JONES, M. D.

Registrar

JAN 16 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Jan 14, 1927

17

I HEREBY CERTIFY, That I attended deceased from Dec 24, 1926, to Jan 14, 1927

that I last saw h[illegible] alive on Jan 14, 1927

and that death occurred, on the date stated above, at 11:30 P m.

The CAUSE OF DEATH* was as follows:

Pyelonephritis

(duration) ... yrs. 1 mos. 12 ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 1/12/27

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings, Pleural tap

(Signed) Harry Davison, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem Date of Burial 1/16 1927

20 UNDERTAKER Jack Levis ADDRESS 1439 E Balto St

OF DEATH in plain words, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 17936

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

123 E 17936

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2819 Hilldale ave ST. 15-58 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gussie Rosen

(a) RESIDENCE NO. 2819 Hilldale ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? 21 yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | W | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isaac Rosen

6 DATE OF BIRTH (month, day, and year) 1869

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 58 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER [illegible] Daddy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mrs S. Snyder

(Address) 2819 Hilldale ave

Filed JAN 16 1927 C. HAMPSON JONES, M. D. Registrar

For [illegible]

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 14 1927

17

I HEREBY CERTIFY, That I attended deceased from April 15, 1926 to Jan. 14, 1927.

that I last saw h[illegible] alive on Jan. 13, 1927

and that death occurred, on the date stated above, at 7 9 m.

The CAUSE OF DEATH* was as follows:

Gall stones in the common bile duct

(duration) 1 yrs. (?) mos ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? yes about 14 mo ago Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical & lab.

(Signed) Isidore J. Levy M. D.

Jan 19 27 (Address) 2036 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Int Carmel — DATE OF BURIAL 1/16 19 27

20 UNDERTAKER Jack Laws — ADDRESS 1489 W Balt St

CAUSE OF DEATH to be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

913

E 17937

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

59 E 17937

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ) ST. 2-4 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Shaffer

(a) RESIDENCE NO. 322 S. Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | white | Widowed |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1880

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 46 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 0 27

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Schwartz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger

12 MAIDEN NAME OF MOTHER Ida Ginsberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger

14 Informant Ricardo

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JAN 6 1927, 19 C. HARRISON JONES, M.D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan 11, 1927, to Jan 14, 1927, that I last saw h[illegible] alive on Jan 14, 1927 and that death occurred, on the date stated above, at 5-30 a m

The CAUSE OF DEATH* was as follows:

Obesity, Hypertension,
Myocardial Insufficiency
Hypertension

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edward Andrus, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mehrer Friedsh On

DATE OF BURIAL 1/6 1927

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E Baltimore

TION IS very important See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17938

## CERTIFICATE OF DEATH.

90 E 17938

1-PLACE OF DEATH

REGISTERED NO._____

City of BALTIMORE: (No. 815 S. Green St. St., 22-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Sample. (C)

(a) RESIDENCE NO. 815 S. Green St. St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male. | Colored | Widower. |

3a If married, widowed, or divorced HUSBAND of (or) WIFE of: Do not know.

6 DATE OF BIRTH (month, day, and year): Do not know.

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 81 | -------- | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer): 40

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country): Virginia.

PARENTS

10 NAME OF FATHER: Do not know

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country): Do not know.

12 MAIDEN NAME OF MOTHER: Do not know.

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country): Do not know.

14 Informant: Christopher C. Handy. (C)

(Address): 426 N. Barre St.

15 Filed JAN 16 1927 19 C. Hamilton Jones M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 14, 1927. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the Heart and Kidneys.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) Otto M Reinhardt (Coroner) M. D.

1/16, 1927 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Zion Ct. Date of Burial: Jan 16 1927

20 UNDERTAKER: W. L. Brown & Son ADDRESS: 1611 Eutaw Pl

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Depew ✓

Spec.–7-17-26—A Co.—200 Bks.

E 17939

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

185

E 17939

REGISTERED NO.

1-PLACE OF DEATH University Hospital

City of BALTIMORE: (No. Baltimore St., Ward 4-30

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2-FULL NAME Martha Depew

(a) RESIDENCE NO. 20 Fort Sheridan Rd. St. Glendale, Md. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of James M Depew

6 DATE OF BIRTH (month, day, and year): July 8 1846

7 AGE: Years 80 Months 6 Days 6 IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Frontier (State or country) Ontario

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town) (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) " (State or country)

14 Informant Arthur Depew (Address) 20 Fort Sheridan Road

15 Filed AUG 6 1927 C. HARRISON JONES, M. D. Registrar

Per R.K.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14th 1927

17 I HEREBY CERTIFY, That I attended deceased from 1-8 1927 to 1-14 1927.

that I last saw her alive on 1-14 1927.

and that death occurred, on the date stated above, at 4:50 P.M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Fracture of Tibia

(duration) 1-6 yrs. 27 mos. ds.

18 Where was disease contracted if not at place of death? Glendale, Md.

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Typical Symptoms

(Signed) A. C. Lyons M. D.

, 19 (Address) University Hospital Baltimore, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem. Date of Burial Jan 17 1927

20 UNDERTAKER Cohen and Kelly ADDRESS 3617 Chestnut Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17940

## CERTIFICATE OF DEATH.

94-001

E 17940

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 318 N. Fulton Ave. St. 14-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura Anna Stanley.

(a) RESIDENCE NO. 318 N. Fulton Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Late Charles A. A. Stanley.

6 DATE OF BIRTH (month, day, and year)
November 18, 1841

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 85 | 1 | 15 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Whitehall

(State or country) Balto, County. Maryland.

PARENTS

10 NAME OF FATHER Charles E. Duer.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Elizabeth Ann Norris

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Miss Belle V. Stanley.

(Address) 318 N. Fulton Ave.

Filed JAN 16 1927 HARRY W. JONES, M.D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

January 15, 1927.

17 I HEREBY CERTIFY, That I attended deceased from Dec 15 1926, to Jan 15, 1927, that I last saw her alive on Jan 14, 1927 and that death occurred, on the date stated above, at 1.30 a.m.

The CAUSE OF DEATH* was as follows:

General Infirmities

(duration) 1 yrs. mos. ds.

CONTRIBITORY (Secondary) Bronchitis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Coline Murray, M. D.

Jan 5, 1927 (Address) 1517 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chester Cemetery Chestertown, Maryland.

Date of Burial Jan 17 1927

UNDERTAKER

ADDRESS

Jos Iverdeng & Son 217 S. Paca St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

Gertrude H Miller

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17941

## CERTIFICATE OF DEATH

REGISTERED NO. E 17941

1-PLACE OF DEATH Mercy Hospital 4-30

City of BALTIMORE: (No. ... St. ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude Miller

(a) RESIDENCE NO. Laurel Co. Md. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. mos. 14 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE: Years 2 yr. | Months | Days | IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) Laurel Md.

(State or country)

PARENTS

10 NAME OF FATHER Edward Miller

11 BIRTHPLACE OF FATHER (city or town) Laurel Md

(State or country)

12 MAIDEN NAME OF MOTHER Mary Gill

13 BIRTHPLACE OF MOTHER (City or town) Elkridge Md

(State or country)

14 Informant Edward Miller

(Address) Laurel Md

15 Filed ... 19 ... Registrar

JAN 16 1927 C. HARRISON JONES, M.D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 11 19 27

17 I HEREBY CERTIFY, That I attended deceased from Jan 2 19 27, to Jan 11 19 27, that I last saw h[illegible] alive on Jan 11 19 27 and that death occurred, on the date stated above, at 3:30 p.m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H Shurtleff, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Md. Date of Burial 1/18 19 27

20 UNDERTAKER Geo. E. French ADDRESS Laurel Md

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 17942 — 1-PLACE OF DEATH

161-001

E 17942 — REGISTERED NO.

City of BALTIMORE: (No.) 3505 Gunnmont (Ward) 29-47

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Christakos

(a) RESIDENCE NO. 3505 Gunnmont St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Jan 15-1927

7 AGE — Years | Months | Days | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Balto

(State or country)

PARENTS

10 NAME OF FATHER: Louis Christakos

11 BIRTHPLACE OF FATHER (city or town): Greece

(State or country)

12 MAIDEN NAME OF MOTHER: Hannah Lenter

13 BIRTHPLACE OF MOTHER (city or town): New York

(State or country)

14 Informant: Louis Christakos

(Address) 3505 Gunnmont

15 Filed ..... 19 ..... Registrar

JAN 16 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 15-1927

17 I HEREBY CERTIFY, That I attended deceased from 1-15 1927, to 1-15 1927

that I last saw him alive on 1-15 1927, at 7:45 P. m.

and that death occurred, on the date stated above, at 7:45 P. m.

The CAUSE OF DEATH* was as follows: Pyuria Burn about 6 months

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward Lent M. D.

1/16 19 27 (Address) 413 Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — Date of Burial: Jan 16 1927

20 UNDERTAKER: John M Weber — ADDRESS: 1803 Bank St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 17943
1-PLACE OF DEATH

90 E 17943
REGISTERED NO.

CITY OF BALTIMORE: (No. 3309 Mueller ST. No. 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam Kruszewski

(a) RESIDENCE No. 3309 Mueller ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | Widower |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1881

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 46 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mrs. Catherine Kaminski Daughter
(Address) 830 N Lakewood ave

15 Filed ..... 19 ..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 13. 1927. to Jan. 14 1927.
that I last saw him alive on Jan. 14. 1927
and that death occurred, on the date stated above, at 11 A m
The CAUSE OF DEATH* was as follows:

acute Cardiac Dilitation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic myocarditis.

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P. S. & S.

(Signed) John J. Finger, M. D.

, 19 (Address) 2627 Eastern ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL

St Stanislaus cem Jan 17 1927

20 UNDERTAKER ADDRESS

John M Weber 1803 Bank st

TION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17944

## CERTIFICATE OF DEATH.

101-901 E 17944

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 109 S Washington ST. 2-4 WARD)

2-FULL NAME William Katechi

(a) RESIDENCE No. 109 S Washington ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 14 1917

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 9 | 9 | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Ignatius Katechi

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Anna Usler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mr Ignatius Katechi Father

(Address) 109 S Washington St

15 Filed ....., 19 ..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 5, 1927, to Jan. 14, 1927.

that I last saw h in alive on Jan. 14, 1927

and that death occurred, on the date stated above, at 4 A m

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Pneumococcus Septicaemia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas J Heinig Co, M. D.

1/15. 1927 (Address) 2007 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary cem DATE OF BURIAL Jan 17 1927

20 UNDERTAKER John McWeber ADDRESS 1803 Bank St

TION is very important See instructions on back of certificates.

Spec.—1-12-[illegible]—500 Blks.

1981 32

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17945

## CERTIFICATE OF DEATH.

E 17945

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ST. 8-16 WARD)

REGISTERED NO. 123

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Wise

(a) RESIDENCE NO. 1621 N. Fulton Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Wise

6 DATE OF BIRTH (month, day, and year) July 7th 1847

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs or ... min. |
|---|---|---|---|---|
| | 79 | 6 | 7 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) Alexandria (State or country) Virginia

PARENTS

10 NAME OF FATHER Andrew Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Records

15 Filed ..., 19... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 6, 1926, to Jan. 14, 1927.

that I last saw her alive on Jan 14, 1927

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis. Cholecystitis

Cystitis

Myocardial Insufficiency

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. Corley Andrus, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| London Park Cemetery | Jan. 17 1927 |
| 20 UNDERTAKER | ADDRESS |
| Frank Lassahn | Fulton |

TION is very important · See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17946

## CERTIFICATE OF DEATH

× 101-001

E 17946

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. 4-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Bowers

(a) RESIDENCE NO. White Marsh Md St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katie Bowers

6 DATE OF BIRTH (month, day, and year) April 6th 1857

| 7 AGE | Years | Months | Days | IF LESS than 1 day ____ hrs. or ____ min. |
|---|---|---|---|---|
| | 69 | 9 | 8 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Truck Farm

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Co.

(State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph Bowers

11 BIRTHPLACE OF FATHER (City or town) Unknown

(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary E. Myers

13 BIRTHPLACE OF MOTHER (city or town) Unknown

(State or country) Germany

14 Informant Katie Bowers

(Address) White Marsh Md.

15 Filed ____ 19 ____ Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 27 Jan 14

17 I HEREBY CERTIFY, That I attended deceased from Jan 12, 19 27, to Jan 14, 19 27, that I last saw him alive on Jan 14, 19 27, and that death occurred, on the date stated above, at 1:45 P m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis with uremia,
Hypertrophy of prostate & Urethral stricture.

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Pneumonia (Lobar)

(duration) ____ yrs. ____ mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 11/26/27

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings & urine & blood

(Signed) M B Hendrix, M. D.

, 19 (Address) University Hospital Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — Date of Burial Jan 18 19 27

20 UNDERTAKER Frank Kassabaum Sons — ADDRESS Fullerton

JAN 16 1927 C. HARRISON KELLY M.D. Registrar

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17947

## CERTIFICATE OF DEATH.

101-001

E 17947

1-PLACE OF DEATH 32 N. Caroline Street

CITY OF BALTIMORE: (No. ) (ST.) 6-4 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James T. Cook

(a) RESIDENCE NO. 32 N. Caroline ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 20 - 1863

7 AGE: 63 — Years: 64 — Months: 8 — Days: 27 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

040

9 BIRTHPLACE (city or town) (State or country): Montgomery County Maryland

PARENTS

10 NAME OF FATHER: James T. Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country): Montgomery Co. Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Montgomery Co. Md.

14 Informant: Maggie Forrest

(Address) 628 N. Caroline St

15 Filed JAN 15 1927 19

C. HARRISON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1-14 1927

17 I HEREBY CERTIFY, That I attended deceased from 1-14-27, 19 , to 1-14-27 19 ,

that I last saw h— alive on 1-14-27, 19 ,

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Acute Croupous Pneumonia

Pulmonary Edema.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. B. Bullock, M. D.

, 19 (Address) 425 N. Carlton St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: 1-17 1927

20 UNDERTAKER: Jas. W. Skinner

ADDRESS: 1625 E. Fund

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17948

## CERTIFICATE OF DEATH.

94 E 17948

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 11-15 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward F. Straubaugh

(a) RESIDENCE NO 1115 Barclay St ST., ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Straubaugh

6 DATE OF BIRTH (month, day, and year) Nov. 7-1871

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 55 | 2 | 7 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cigar Maker
(b) General nature of industry, business, or establishment in which employed (or employer) 17
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Aloysius Straubaugh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Geckeis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Orleans

14 Informant Annie Straubaugh
(Address) 1115 Barclay St

15 Filed JAN 16 1927 H. HAMPSON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-14 2-3 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

Duration — (duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) ..... M. D. (Coroner.)

Jan 15 192 7 (Address) 6 E Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ..... mos., ..... ds. In the State ..... yrs., ..... mos., ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Cathedral Cemetery | 1-17 192 7 |
| UNDERTAKER | ADDRESS |
| Chas. F. Maus & Son | 11 W. Mt. Royal Ave |

TION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17949

## CERTIFICATE OF DEATH.

179 E 17949

REGISTERED NO.

1-PLACE OF DEATH Church Home & Infirmary

City of BALTIMORE: (No. 1501 Broadway St. Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Katherine M. Snyder

(a) RESIDENCE NO. 3304 Forest Park St. Ward 8 Balto. Md.

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Patrick Snyder

6 DATE OF BIRTH (month, day, and year): Dec 17-1842

7 AGE — Years: 84 — Months: — — Days: 29 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country) Ohio

PARENTS

10 NAME OF FATHER Frank Chase

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Ohio

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Unknown

14 Informant: Jos. T. Barry

(Address) 3304 Forest Park Ave

15 Filed JAN 18 1927 H. HARRISON JONES, M. D., Registrar

For RK

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: Jan 16 1927

17 I HEREBY CERTIFY, That I attended deceased from 1-12-, 1927, to 1-15-, 1927,

that I last saw her alive on 1-15-, 1927,

and that death occurred, on the date stated above, at 7 05 a.m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

Myocardial failure

Nephritis, chro. Interst.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, Sen.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No

Was there an autopsy? Yes

What test confirmed diagnosis? Broncho Pneum. Lt. lung.

(Signed) J. H. McCracken, M. D.

, 19 (Address) Church Home & Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary's Cem. Hampden — Date of Burial 1/18 1927

20 UNDERTAKER: Chas. S. Franc & Son — ADDRESS 118 W. Mt. Royal Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 17950

REGISTERED NO. E 17950

1-PLACE OF DEATH

City of BALTIMORE: (No. 104 N Poppleton St., 18-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Emma Paul

(a) RESIDENCE NO. 64 N Poppleton St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | Colored | widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Paul

6 DATE OF BIRTH (month, day, and year) unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 49 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) H

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Alexander Williams

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Jane Gary Gary

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Ethel L. Sears

(Address) 1544 N. Poppleton St.

15 Filed ..... 19..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 12 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1926, to January 12, 1927, that I last saw h[illegible] alive on January 12, 1927, and that death occurred, on the date stated above, at 3:10 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) ....yrs. 6 mos. ....ds.

CONTRIBUTORY

(Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis

(Signed) H. S. McCard, M. D.

1/13, 1927 (Address) 2005 Druid Hill

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Atlantic City, N. J.

20 UNDERTAKER

Mrs. Katie R. Williams

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17951

## CERTIFICATE OF DEATH.

31

26-42

REGISTERED NO. E 17951

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 18 Belleview Ave Raspeburg, ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret J. Smith Richards

(a) RESIDENCE No. 18 Belleview Ave. Raspeburg, ST., 26 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Claude Richards

6 DATE OF BIRTH (month, day, and year) May 12, 1881

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 45 | 8 | 2 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Annie von Erda

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Holland

14 Informant Claude Richards
(Address) 18 Belleview Ave. Raspeburg

15 Filed JAN 16 1926 19 C. HAMPTON JONES, M. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 14, 1927

17

I HEREBY CERTIFY, That I attended deceased from December 22, 1926, to January 14, 1927,

that I last saw her alive on January 13, 1927,

and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 16 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. L. Wilkinson, M. D.

A. L. Wilkinson

1/14 1927 (Address) Raspeburg, Maryland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL 1/17 1927

20 UNDERTAKER D. William Cook — ADDRESS 502 E North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

E 17952

## CERTIFICATE OF DEATH.

E 17952

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1845 N. Collington Ave. St. 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Rappe

(a) RESIDENCE NO. 1845 N. Collington St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Johanna

6 DATE OF BIRTH (month, day, and year): July 2 1857

7 AGE: Years 69 | Months 6 | Days 13 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Night Watchman

(b) General nature of industry, business, or establishment in which employed (or employer): Steel Co

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Henry Rappe

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Johanna Rappe

(Address) 1845 N. Collington

15 Filed JAN 16 1927, 19 C. HAMPSON JONES, M.D. Registrar

By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 15 1927

17 I HEREBY CERTIFY, That I attended deceased from January 9, 1927, to January 15, 1927, that I last saw h.. alive on January 15, 1927, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..yrs. ..mos. 6 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 3 yrs. ..mos. ..ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) P. Will Thomas, M. D.

(Address) 1278 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel Date of Burial Jan 17 1927

20 UNDERTAKER: D. Wm Cook ADDRESS 502 E. North Ave

One space to be allowed for each syllable. Avoid abbreviations. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17953

## CERTIFICATE OF DEATH.

90 E 17953

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1217 W. Mulberry St. 18 W. WARD)

2-FULL NAME W. Wesley Swartz

(a) RESIDENCE NO. 1217 W. Mulberry ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret J. Swartz

6 DATE OF BIRTH (month, day, and year): Sept 17, 1847

7 AGE — Years: 79 — Months: 3 — Days: 27 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Penna

PARENTS

10 NAME OF FATHER: William Swartz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant: Rev. D. E. Moylan (Address) 1217 W. Mulberry St

JAN 16 1927 Filed, 19 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 14 1927

17

I HEREBY CERTIFY, That I attended deceased from Nov. 23, 1925, to Jan. 14, 1927,

that I last saw him alive on Jan. 14, 1927,

and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 1 yrs. 1 mos — ds.

CONTRIBUTORY (Secondary) Cardiac Dumpiency

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Findings

(Signed) John A. Buchanan, M. D.

, 19 (Address) 37 S. Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Kingston Penna

UNDERTAKER: Wm Cook

DATE OF BURIAL: 1/18 1927

ADDRESS: 502 E 16th

CAUSE OF DEATH to plain terms, so that it may be properly classified. EXAMINATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 17954

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

98 E 17954

1-PLACE OF DEATH

City of BALTIMORE: (No. 212 Ennel Ave St. 27-44 Ward)

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Voyce

(a) RESIDENCE NO. 212 Ennel Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Myrtle Voyce

6 DATE OF BIRTH (month, day, and year) unknown.

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 41 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer) B & O R R

(c) Name of employer

9 BIRTHPLACE (City or town)

(State or country) Balto. Md

PARENTS

10 NAME OF FATHER Wm H. Voyce

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Ella Clinton

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto. Md

14 Informant Myrtle Voyce

(Address) 212 Ennel Ave.

15 Filed 19 Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 13th 27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Laryngitis

over

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Odema of throat 4 or 5 hrs.

(duration) yrs. mos. ds.

(Signed) J. H. Bates M. D.

(Coroner)

1/15/27 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 1/17 1927

20 UNDERTAKER L. Gladstone Sons ADDRESS 1314 Eutaw St.

Don should be carefully supplied. AGE should be stated OF DEATH in plain terms, so that it may be properly very important. See instructions on back of certificate.

JAN 16 1927 C. HOMER JONES, M. D.

Davis

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17955

## CERTIFICATE OF DEATH.

112 E 17955

1-PLACE OF DEATH

City of BALTIMORE: (No. 3716 Roland Ave St. 43 Ward)

REGISTERED NO. 3352

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roxie A Davis

(a) RESIDENCE NO. 3716 Roland Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 26 / 18[illegible]

7 AGE — Years: 84 — Months: 11 — Days: 20 — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Va

PARENTS

10 NAME OF FATHER William Gresom

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Rebb Davis

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant M E Davis

(Address) 3600 Elm ave

15 Filed JAN 18 1926 C. HENRY JONES JR. Registrar

By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14 / 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 1 1925 to Jan 14 1927

that I last saw h alive on Jan 14 1927

and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

I Carcinoma of Stomach

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Gastric Hemorrhage

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) A B Richard, M. D.

1.15.1927 (Address) 3642 Clarks Ln

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge — Date of Burial: Jan 17 1927

20 UNDERTAKER: M E Gresom — ADDRESS: 847 W Pratt St.

Don't should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17956

## CERTIFICATE OF DEATH.

E 17956

REGISTERED NO. 57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4500 Fendale Ave. 28-64 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth M. Jacobs

(a) RESIDENCE. NO. 4802 Fendale Ave. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of James A. Jacobs

6 DATE OF BIRTH (month, day, and year) 6/8/58

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 68 | 7 | 5 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Michael Burns

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Healy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Mrs. L. Logan 4802 Fendale Ave

Filed JAN 16 1927 H. HAMPTON JONES, M. D. Registrar

Per L K

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 13 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 6. 1927. to Jan 13. 1927.

that I last saw h alive on Jan 13. 1927.

and that death occurred, on the date stated above, at 4 10 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no .

What test confirmed diagnosis? Clinical.

(Signed) A. C. Smith, M. D.

Jan 15. 1927 (Address) 4309 Liberty Hgts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| New Cathedral Cem | 1/17/27 |
| 20 UNDERTAKER | ADDRESS |
| J. J. Doley & Sons | 1312 Light |

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 17957

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17957

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1313 N Mulberry ST. 14-16 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude Wisch

(a) RESIDENCE No. 1313 " " ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 7, 1927

7 AGE: Years — Months — Days 8 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Sophie Wisch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Nathalie Wisch (Address) 1313 W. Mulberry St.

15 Filed JAN 18 1927, 19 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/15- 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 8, 1927, to Jan 15, 1927.

That I last saw h alive on Jan 15, 1927.

and that death occurred, on the date stated above, at 5-30 A m.

The CAUSE OF DEATH* was as follows:

Internal Hemorrhage
Peritoneal

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Thyroid goiter

(Signed) Chas A Cook M. D.

1/15- 1927 (Address) 2105 N Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery.

DATE OF BURIAL: Jan 17, 1927

20 UNDERTAKER: Chas. W. Dill.

ADDRESS 3109 Fredk Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

E 17958

# HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 17958

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 2409 Roslyn Ave ST.; 15 WARD 61

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret M. Eckert

(Residence in Baltimore: No. 2409 Roslyn Ave St.; ..... yrs., ..... mos. ..... ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

| 3-SEX. | 4-COLOR OR RACE, | 5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) |
|---|---|---|
| Female | White | Single |

6-DATE OF BIRTH, Sept 1, 1861
(Month) (Day) (Year)

7-AGE, 65 yrs. 4 mos. 13 ds.

If LESS than 1 day, .... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... General

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Conrad Eckert

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Margaret Hack

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Mary M. Mack

(Address)..... 2409 Roslyn Ave

15-

Filed..... 1927 C. HAMPSON JONES, M. D., Registrar.

By..... K C

JAN 16 1927

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 14, 1927
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 15 1926, to Jan 14 1927, that I saw her alive on Jan 14 1927, and that death occurred, on the date stated above, at 3:50 p. m.

The CAUSE OF DEATH* was as follows:

..... Nephritis

..... Chronic (Duration)..... yrs..... mos. ..... ds.

CONTRIBUTORY (Secondary) Failing Compensation

..... about (Duration)..... yrs. 2 mos..... ds.

(Signed)..... Edward C. Smuck M. D.

Jan 14, 1927 (Address)..... 920 S. Paca St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

| 19-PLACE OF BURIAL, OR REMOVAL, | DATE OF BURIAL, |
|---|---|
| Holy Redeemer Cem. | 1/17, 1927 |
| 20-UNDERTAKER, Henry A. Myers & Son | ADDRESS 805 N. Calvert |

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

E17959

# HEALTH DEPARTMENT—CITY OF BALTIMORE

17959.

38 E17959

## CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. ____ St., 913 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Grayson

(a) RESIDENCE NO. 1516 E. Madison St. ____ Ward ____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | Negro | Married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1882

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 45 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) ____

(State or country) Va

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ____

(State or country) ?

12 MAIDEN NAME OF MOTHER Elizabeth -

13 BIRTHPLACE OF MOTHER (city or town) ____

(State or country) Va

14

Informant ____

(Address) Records

Filed JAN 16 1927 C. HAMPSON JONES, M. D. Registrar

By E M

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 13 1927

17

I HEREBY CERTIFY, That I attended deceased from January 11 1927, to January 13, 1927, that I last saw him alive on January 13, 1927, and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebro Spinal Meningitis unknown etiology (Lustic or tuberculous)

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY ____

(Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of ____

Was there an autopsy? no

What test confirmed diagnosis? General & Pathology.

(Signed) L. D. Cooper Smith M. D.

Jan 13 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Purcellville Va Date of Burial Jan 17 1927

20 UNDERTAKER Robert E Williams ADDRESS 1615 Mc Elderry St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

✓ 17960

# HEALTH DEPARTMENT—CITY OF BALTIMORE

**E 17960** CERTIFICATE OF DEATH. 129 **E 17960**

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1122 N. Barclay ST. 11-15 (WARD)

2-FULL NAME Francis X. Satterfield

(a) RESIDENCE No. 1122 Barclay ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Stella Satterfield

6 DATE OF BIRTH (month, day, and year) 7/1/10 1886

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 40 | 2 | 5 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer R. R Railroad

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Ed. Satterfield

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Kath. Whalen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Stella Satterfield (Address) 1122 Barclay St

15 Filed JAN 16 1927 HAMPSON JONES, M. D. Registrar

By

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1926, to Jan 14 1927.

that I last saw h[illegible] alive on Jan 14 1927.

and that death occurred, on the date stated above, at 8.45 P. m.

The CAUSE OF DEATH was as follows:

Chronic Myocarditis

Senile

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. Angus L. Ludlow, M. D.

1/15 1927 (Address) 332 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem. DATE OF BURIAL Jan 17 1927

20 UNDERTAKER Geo. M. Frost & Son ADDRESS [illegible]

INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&S—500 Bks.

✓ 17961

E 17961

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 17961

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. 8-17 ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leola Schlecter

(a) RESIDENCE NO. 2031 E. Ellsworth Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 8½ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | white | single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12-15-25

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 1 | | 25 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Albert Schlecter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Gertrude Rosenstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JAN 16 1927 19 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec. 30, 1926, to Jan. 14, 1927, that I last saw h e alive on Jan. 14, 1927 and that death occurred, on the date stated above, at 7 30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Microcephaly

(duration) yrs. 15 mos. ds.

CONTRIBUTORY (Secondary) Otitis Media

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? X-ray

(Signed) Thomas W. Cornwell M. Dr

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Mt. Carmel Cem | Jan 17 1927 |
| 20 UNDERTAKER | ADDRESS |
| Geo M. Frid & Son | Baltimore |

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17962

CERTIFICATE OF DEATH.

188-007

E 17962

1-PLACE OF DEATH Franklin Sq. Hospital 15-27

City of BALTIMORE: (No. ) St., Ward

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Gertrude McCandlish

(a) RESIDENCE NO. 2024 Edmondson Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 Color or Race White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward McCandlish

6 DATE OF BIRTH (month, day, and year) Sept. 7 1896

7 AGE Years 30 Months 4 Days 8 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Hagerstown

(State or country) Md

PARENTS

10 NAME OF FATHER Joseph Benj. Griffith

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Virginia Ashwood

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Mrs Talia Witerman

(Address) 2024 Edmondson Ave

JAN 7 1927

Filed H. Hanson Jones, M. D. Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15th 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broken neck - fractured skull

(duration) at once yrs. mos. ds.

CONTRIBUTORY (Secondary) motor cycle accident

(duration) yrs. mos. ds.

(Signed) Thos. B. Horton M. D.

(Coroner)

Jan 16 27 (Address) Curtis Bay, Balto Md.

*State the Disease Causing Death, or in deaths from violent causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the state yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hagerstown Md. Date of Burial Jan 8 1927

20 UNDERTAKER J. Wm Pfeltz Sons ADDRESS Route 1 Va

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-27—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17963

CERTIFICATE OF DEATH.

11-002

E 17963

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) Balto City Hosp. (St.) 10-10 (Ward)

2-FULL NAME Grace Graham

(a) RESIDENCE NO. 105 Longwood St. Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 19-1871.

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 55 | 8 | 23 26 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housework

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) Edesville

(State or country) Kent Co. Md.

PARENTS

10 NAME OF FATHER Henry H. Graham

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Kent Co. Md.

12 MAIDEN NAME OF MOTHER Ella Kendall

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Kent Co. Md.

14 Informant Charles E. Coleman

(Address) 105 Longwood St.

15 Filed JAN 17 1927 C. HARRISON JONES, M. D.

Per ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 Jan. 14-1927.

17 I HEREBY CERTIFY, That I attended deceased from 11-20-1920, to 1-14-1927, that I last saw h[illegible] alive on 1-14-1927, and that death occurred, on the date stated above, at 7 30 a.m.

The CAUSE OF DEATH* was as follows: Lobar Pneumonia following Lagrippe of 5 days duration -

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? at Balto city Hosp.

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Phy findings

(Signed) [illegible], M. D.

, 19 (Address) Balto City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. Date of Burial: Jan. 17. 1927

20 UNDERTAKER: Lilly & Zilm ADDRESS: 403 S. Wolfe St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 17964 — 109-002

E 17964 — REGISTERED NO.

1-PLACE OF DEATH University Hospital

City of BALTIMORE: (No. Lombard & Greene St. 17-19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Phelps, Laura

(a) RESIDENCE NO. 2627 St. Paul St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | white | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 18 1870

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|---|
| | 50 | 9 | 27 28 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home d°

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Richard B Phelps

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Mary E. Cole

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Mr. R. B. Phelps

(Address) 2224 Mayfield Ave

15 Filed JAN 17 1927 — 16 C. HARRISON JONES, M. D. Registrar — Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1 - 15 - 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 4, 1927 to Jan 15, 1927.

that I last saw her alive on Jan 15, 1927

and that death occurred, on the date stated above, at 3 42 a m.

The CAUSE OF DEATH* was as follows:

Generalized Vincent's Angina

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Laboratory & physical findings

(Signed) Will C. LaCorte M. D.

Jan 15 1927 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Friendship Cem. Ga. Co. Md. Jan 17 1927

20 UNDERTAKER — ADDRESS

Wm. J. Tickner & Sons Govans Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 17965

E 17965

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. St Agnes Hospital St. 25-72 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Gilda

(a) RESIDENCE NO. Bowman Av Catonsville St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1-9-27.

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min.. |
|---|---|---|---|---|
| | 6 days. | | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md

(State or country)

PARENTS

10 NAME OF FATHER John Gilda

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Do not know

12 MAIDEN NAME OF MOTHER " " "

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) " " "

14 Informant John Gilda

(Address) Bowman Av. Catonsville

Filed JAN 17 1927 C. HAMPSON JONES, M. D.

For Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-15- 1927

17 I HEREBY CERTIFY, That I attended deceased from 1-9, 1927, to 1-15, 1927, that I last saw him alive on 1-15, 1927, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Patent ductus arteriosus

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Theron Hunter, M. D.

1/15. 1927 (Address) St. Agnes' Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Forest Ridge Cem — Date of Burial: Jan 17 1927

20 UNDERTAKER: Wm Tucker Sons — ADDRESS: Catonsville Md

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17966

## CERTIFICATE OF DEATH.

129 E 17966

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 235 N. Carrollton Ave ST. 18-26 WARD)

2-FULL NAME Elizabeth E. Nichols

(a) RESIDENCE NO. 235 N. Carrollton Ave ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 6 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | white | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George P. Nichols

6 DATE OF BIRTH (month, day, and year) July 2, 1860

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs or ..... min. |
|---|---|---|---|---|
| | 66 | 6 | 5 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Finnadge King

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary C. Conway

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Dr. J. C. Nichols

(Address) 710 Cathedral St.

15 Filed JAN 7 1927 HOWARD JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 14, 1927, to Jan 14, 1927, that I last saw her alive on Jan 14, 1927, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH was as follows:

Chronic Bronchitis

Myocarditis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Chron. Nephritis

(duration) 1 yrs. mos. ds.

Cardio-Nephritis

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Vernon F. Kelly M. D.

1/15, 1927 (Address) 4 Somerset Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Loudon Park Cem. Co. | Jan. 17, 1927 |
| 20 UNDERTAKER | ADDRESS |
| John A. Mitchell | 1910 Eutaw Pl. |

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

E 17967

CERTIFICATE OF DEATH.

167-001

E 17967

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hospital St., 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Isabelle Kistner

(a) RESIDENCE NO. 739 N. Fulton Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Herman H. Kistner

6 DATE OF BIRTH (month, day, and year): Sept. 6, 1884

7 AGE: Years 42 | Months 4 | Days 9 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Saleslady

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: The Hub

9 BIRTHPLACE (city or town): Elizabeth

(State or country): New Jersey

PARENTS

10 NAME OF FATHER: William S. Armstrong

11 BIRTHPLACE OF FATHER (city or town):

(State or country): United States

12 MAIDEN NAME OF MOTHER: Julia Larkin

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): United States

14 Informant: Colonial Hospital Records

(Address) 1122 N. Mount St.

Filed JAN 17 1927 HAMPSON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 15, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxia by gas inhalation

(Gas escaping from stove)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D. (Coroner)

Jan. 16, 1927. (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Elizabeth, New Jersey Date of Burial: Jan 17 1927

UNDERTAKER: Joseph L. Cook ADDRESS: 1003 N. Eutaw St.

N. B.—WRITE PLAINLY, WITH INDIA INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17968

E 17968

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. 19-27 ST. WARD)

REGISTERED NO. 161

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Audrey Barton

(a) RESIDENCE NO. 510 Vincent ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: col

5 Single, Married, Widowed, or Divorced. (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years | Months: 2 | Days | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Earl Hamon

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Virginia Barton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JAN 17 1927, 19 C. HAMPSON JONES, M. D. Registrar

For LK

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 11, 1927. to Jan. 11, 1927.

that I last saw h e alive on Jan 11, 1927

and that death occurred, on the date stated above, at 9 0 m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? History

(Signed) Thomas K. Cromwell, M. D.

(Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL 1/14

20 UNDERTAKER: JOHNS HOPKINS HOSPITAL — ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17969

## CERTIFICATE OF DEATH.

E 17969

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 824 Edmondson Av (or) ST. 19-26 WARD)

2-FULL NAME Jennie Adams Brown

(a) RESIDENCE. No. 824 Edmondson Av ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Nathan Brown

6 DATE OF BIRTH (month, day, and year): Oct - 1874

7 AGE: Years 52 | Months 3 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Plymouth N C.

PARENTS

10 NAME OF FATHER: Matthias Maitland

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. C.

12 MAIDEN NAME OF MOTHER: Edna Gudan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N C.

14 Informant: Katherine Butler

(Address): 824 Edmondson Ave

15 Filed JAN 7 1927, 19 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 2 1927 to Jan 14 1927

that I last saw h alive on Jan 14 1927

and that death occurred, on the date stated above, at 6.25 P m.

The CAUSE OF DEATH* was as follows:

Endocarditis & Nephritis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Dr. Carter, M. D.

19 (Address) 824 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery — DATE OF BURIAL: Jan 18 1927

20 UNDERTAKER: Geo. W. Close & Son — ADDRESS: 1400 Pitcher

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Ca—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

**E 17970**

## CERTIFICATE OF DEATH.

101-001

**E 17970**

REGISTERED NO.

1-PLACE OF DEATH Mercy Hospital

City of BALTIMORE: (No. ..... St. ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Luther Koehler.

(a) RESIDENCE NO. 3 Eastern Ave St. ..... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| M | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 1879

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 47 | 11 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) .....

(State or country) Baltimore

PARENTS

10 NAME OF FATHER William Koehler

11 BIRTHPLACE OF FATHER (city or town) .....

(State or country) Germany

12 MAIDEN NAME OF MOTHER Cecelia Dingang

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) Germany

14 Informant Martin Ludwig

(Address) 42 Grinder Ave

15 Filed JAN 7 1927 H. JAMES JONES, Jr. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 14, 1927, to Jan 16, 1927, that I last saw h— alive on Jan 16, 1927, and that death occurred, on the date stated above, at 11 45 A. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted

If not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) P Gunella, M. D.

(Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem. Date of Burial Jan 18 1927

20 UNDERTAKER John Ulerich ADDRESS 2008 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE.

## CERTIFICATE OF DEATH.

E 17971
1-PLACE OF DEATH

REGISTERED NO. E 17971

CITY OF BALTIMORE: (No. 1921 Mt. Elderry ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas H Bowen

(a) RESIDENCE NO. 1921 Mt. Elderry ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna L. Bowen

6 DATE OF BIRTH (month, day, and year) Mar 4 - 1867

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 59 | 10 | 10 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stevedore Foreman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS
10 NAME OF FATHER Don't Know
11 BIRTHPLACE OF FATHER (city or town) (State or country) Md
12 MAIDEN NAME OF MOTHER Don't Know
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Anna L. Bowen
(Address) 1921 Mt. Elderry Ave.

15 Filed JAN 17 1927 C. HAMPSON JONES, M. D. Registrar
Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14 1927

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1926, to Jany 14, 1927.
that I last saw h[illegible] alive on Jany 14 1927.
and that death occurred, on the date stated above, at 8 & 10 P. m.
The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Cerebral Embolism
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? no

(Signed) Gustav Kieffer, M. D.
Jan 17, 1927 (Address) 2320 Bull Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem
DATE OF BURIAL Jan 17 1927

20 UNDERTAKER John Ullrich
ADDRESS 208 S Eden

INSTRUCTIONS: Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 17972

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

101-001

E 17972

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 606 N. Bethel St

CITY OF BALTIMORE: (No. 606 ST., N. Bethel WARD 7-9)

2-FULL NAME Samuel J. Watkins

(a) RESIDENCE NO. 606 N. Bethel ST., ... WARD ...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary A. Watkins

6 DATE OF BIRTH (month, day, and year): 1867

7 AGE — Years: 60 — Months: — Days: — If LESS than 1 day, ... hrs or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Fireman

(b) General nature of industry, business, or establishment in which employed (or employer): Equitable Bldg. Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Emanuel J. Watkins

11 BIRTHPLACE OF FATHER (city or town) (State or country): M. D

12 MAIDEN NAME OF MOTHER: Mary A. Jennings

13 BIRTHPLACE OF MOTHER (city or town) (State or country): M. D

14 Informant: Mary Walker

(Address): 1309 W. Saratoga st

Filed JAN 17 1927, 19 C. HAMPSON JONES, M. D.

Per ... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1-14-27 19

17

I HEREBY CERTIFY, That I attended deceased from 1-11-27, 19 ... to 1-14-27, 19 ...

that I last saw h[illegible] alive on 1-14-27, 19 ...

and that death occurred, on the date stated above, at 12 20 P. m.

The CAUSE OF DEATH* was as follows:

Coronary Pneumonia

Pulmonary Edema

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. B. Butler, M. D.

, 19 (Address) 425 S. Carlton st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Zion cemetery — DATE OF BURIAL: Jan 17 1927

20 UNDERTAKER: Edward Bryan — ADDRESS: 1691 orleans st

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks. Palo Santoluchita

HEALTH DEPARTMENT—CITY OF BALTIMORE

118-002

# CERTIFICATE OF DEATH.

E 17973

REGISTERED NO. E 17973

1-PLACE OF DEATH

City of BALTIMORE: (No. Maryland General Hosp. St. 26-2 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Palo Santoluchita

(a) RESIDENCE NO. 221 S. Clinton St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 12th 1927

7 AGE — Years: — Months: 1 — Days: 14 29 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md

(State or country)

PARENTS

10 NAME OF FATHER Oretzio Santoluchita

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Italy

12 MAIDEN NAME OF MOTHER Paula Mangano

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Italy

14 Informant Oretzio Santoluchita

(Address) 221 S. Clinton St

Filed JAN 7 1928 19 C. HAMPSON JONES, M.D. Registrar

Per RJ

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 15, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis,

(duration) .....yrs. .....mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) J. C. Kennedy M. D.

(Coroner)

Jan 3 1928 (Address) 2812 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — Date of Burial: Dec 17th 1927

UNDERTAKER: Frank V. Lupetora — ADDRESS: 2915 E. Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 17974

## CERTIFICATE OF DEATH.

E 17974

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Seligman

(a) RESIDENCE NO. 257 South Ann St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jennie Seligman

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 50 | Months — | Days — | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Russia

14 Informant (Address) Jennie Seligman 259 S. Ann St

JAN 17 1927

HAMSON JONES, M. D.

Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Jan 17, 1927

I HEREBY CERTIFY, That I attended deceased from Dec 25, 1926, to Jan 17, 1927, that I last saw him alive on Jan 17, 1927, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Tenical Arteriosclerosis

Hypertrophied Prostate

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Terminal Bronchopneumonia (duration) 4 yrs. — mos. 3 ds.

17 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 1/14/27.

Was there an autopsy? No

What test confirmed diagnosis? Yes

(Signed) C. Hyman, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rehrem Herrn Rus

Date of Burial 19 27

20 UNDERTAKER: Jack Lewis

ADDRESS 1434 E Balt St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17975

## CERTIFICATE OF DEATH.

90 E 17975

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 603. Richmond ave ST., 1424 WARD)

2-FULL NAME Anne. W. Ritter

(a) RESIDENCE NO. 603 Richmond ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married,~~ ~~or Divorced,~~ (write the word): Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Late William L. Ritter

6 DATE OF BIRTH (month, day, and year): Sept 23 1859

7 AGE: Years 67; Months 3; Days 21; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED:

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Daniel Barly.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Dora Schaller

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Albert. F. Ritter

(Address): Elgin ave. bet. Hamilton

15 Filed JAN 17 1927 HAMPSON JONES, M. D. Registrar

By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 15 1927

17 I HEREBY CERTIFY, that I attended deceased from: Dec 25, 1926, to Jan 15, 1927, that I last saw h[illegible] alive on Jan 14, 1927 and that death occurred, on the date stated above, at 3 A.m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

with Auricular Fibrillation

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas Smith, M. D.

1/18/27 (Address) 4706 Harford

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore County. DATE OF BURIAL: Jan 17 1927.

20 UNDERTAKER: Geo. L. Ruth. ADDRESS: 1730 Harford

Spec.—1-12-23—M&T—500 Bks.

# E 17976 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 17976

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1109 N Eden ST., 10-13 WARD)

2-FULL NAME Anna Era Fleckenstein

(a) RESIDENCE NO. 1109 N Eden ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? 80 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 ~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~. (write the word) |
|---|---|---|
| Female | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late John Fleckenstein

6 DATE OF BIRTH (month, day, and year) Nov 4 1846

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 80 | 2 | 11 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER George Fleckenstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Ruhl

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant George Fleckenstein (Address) 1109 N. Eden st

15 Filed ... 19 HAMP H. JONES Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 15 1927

17

I HEREBY CERTIFY, That I attended deceased from ..., 19.., to January 15, 1927.

that I last saw her alive on ..., 1927.

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

3 hours (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Warner, M. D.

, 1927 (Address) 2133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL Jan 7 1927

20 UNDERTAKER George J. Ruth — ADDRESS 1735 Hufeland ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JAN 17 1927

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17977

## CERTIFICATE OF DEATH.

1249

E 17977

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Freeway Apts 3401 N. Charles St ST. ..... WARD)

2-FULL NAME William Lincoln Andrews

(a) RESIDENCE NO. Freeway Apts 615 3401 N. Charles St. ST., ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha Piper

6 DATE OF BIRTH (month, day, and year) Sept 30 1865

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 61 | 3 | 15 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Vice Pres. 186

(b) General nature of Industry, business, or establishment in which employed (or employer) Continental Coal Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wellsville Ohio

PARENTS

10 NAME OF FATHER John Kennedy Andrews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Sarah Jane Wood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant Mrs Martha A Andrews (Address) Freeway Apts

15 Filed JAN 17 1927 E. HAMPTON JONES, M.D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/15 1927

17 I HEREBY CERTIFY, That I attended deceased from 1/11, 1927, to 1/14, 1927, that I last saw him alive on 1/14, 1927, and that death occurred, on the date stated above, at 12:20 A m.

The CAUSE OF DEATH* was as follows:

Mitral stenosis & regurgitation; general arteriosclerosis

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebral arteriosclerosis (duration) 2 yrs. 6 mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) E. Blackwell, M. D.

1927 (Address) 1403 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cem

DATE OF BURIAL Jan 17 1927

20 UNDERTAKER Harry W. Perkins Sons Co

ADDRESS Charles & Oxford

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

E 17978

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 17978

REGISTERED NO.

1-PLACE OF DEATH Woman's Hospital.

City of BALTIMORE: (No. John + Lafayette St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Minnie Sharrer

(a) RESIDENCE NO. Center + Willis St., Westminster Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jesse C. Sharrer

6 DATE OF BIRTH (month, day, and year): Nov. 8, 1865

7 AGE: Years 61 Months 2 Days 9 IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md.

PARENTS

10 NAME OF FATHER: William Wicke

11 BIRTHPLACE OF FATHER (City Alsace-Lorraine

(State or country) Germany.

12 MAIDEN NAME OF MOTHER: Mary J. Dettier

13 BIRTHPLACE OF MOTHER (city or town) Manchester

(State or country) Carrol County, Md.

14 Informant: Mrs. Harry Miller,

(Address) 1022 W. Lanvale St.

15 Filed JAN 17 1927 19

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 17, 1927.

17 I HEREBY CERTIFY, That I attended deceased from Dec. 27, 1926 to Jan. 17, 1927, that I last saw h[illegible] alive on Jan. 17, 1927, and that death occurred, on the date stated above, at 1:05 A. m.

The CAUSE OF DEATH* was as follows:

Hypertension.
Cardiac dilatation & hypertrophy.
Dilated aortic arch.

(duration) Several yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute circulatory collapse, & acute dilatation of the heart (duration) — yrs. — mos. 5 min.

18 Where was disease contracted

If not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? B. P.; finding's in chest.

(Signed) Wm. Wier M. D.

, 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westminster, Md. Date of Burial: Jan 19 1927

20 UNDERTAKER: W. Maurice Kontzen ADDRESS: Baltimore 2238 W. North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17979

# CERTIFICATE OF DEATH.

101-001

E 17979

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 717 St. Peters St. 21-29 Ward)

2-FULL NAME Clarence M. Allers

(a) RESIDENCE NO. 717 St Peters St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie Petrosky Allers

6 DATE OF BIRTH (month, day, and year): September 29 1877

7 AGE: Years 50 | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer): Ob

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Harmon C. Allers

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Regina Ruff

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: George W. Allers

(Address) 717 S. Paca St

15 Filed JAN 17 1927 C. HAMPSON JONES, M. D. Registrar

For B.K.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 16 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan 14 1927, to Jan 16 1927,

that I last saw h[illegible] alive on Jan 15 1927,

and that death occurred, on the date stated above, at 2 [illegible] m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) ____ yrs. ____ mos. 2 ds.

CONTRIBUTORY (Secondary) Cirrhosis

(duration) ____ yrs. 1 mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of ____

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

1927, (Address) 32 Hood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Date of Burial Jan 18 1927

20 UNDERTAKER: Margaret J. Flynn ADDRESS: 1222 Light

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17980

## CERTIFICATE OF DEATH.

101-001

E 17980

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 762 W Mulberry (St.) 18-26 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Cole

(a) RESIDENCE NO. 762 W. Mulberry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | colrd | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1901

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 26 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 020

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. Va

PARENTS

10 NAME OF FATHER Wm Cole

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Annie Cole

(Address) 520 Mulberry St

15 Filed JAN 17 1927, 19 C. HAMPSON JONES, M.D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 8, 1927, to Jan 16, 1927, that I last saw him alive on Jan 14, 1927, and that death occurred, on the date stated above, at 4.45 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) John Cooney, M. D.

, 19 (Address) 762 Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL Jan 17 1927

20 UNDERTAKER Daniel Easton — ADDRESS Pa Ave 24

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17981

## CERTIFICATE OF DEATH.

100-08

E 17981

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 55 Broadway St., 17-25 Ward)

2-FULL NAME Mary E. Davies

(a) RESIDENCE NO. 55 Broadway St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, with UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec. 25, 1926

7 AGE: Years — Months — Days: 21 days — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None, yrs

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Md.

(State or country)

PARENTS

10 NAME OF FATHER Ralph Davies

11 BIRTHPLACE OF FATHER (city or town): Md.

(State or country)

12 MAIDEN NAME OF MOTHER Viola Jones

13 BIRTHPLACE OF MOTHER (city or town): Md.

(State or country)

14 Informant Mary E. Davies

(Address) 55 Broadway

15 Filed JAN 7 1927 C. HAMPSON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 25 1926

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. ds.

(Signed) [illegible] M. D.

(Coroner)

Jan. 19 27 (Address) 2107 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem. — Date of Burial 19 27

20 UNDERTAKER: Daniel Easton — ADDRESS 944 Bond

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17982

101-001

E 17982

## CERTIFICATE OF DEATH

1-PLACE OF DEATH 1602 E Federal St

REGISTERED NO. 8-17

City of BALTIMORE: (No. 1602 E Federal St., or Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elias H Weedon

(a) RESIDENCE NO. 1602 E Federal St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ the late Mollie Weedon

6 DATE OF BIRTH (month, day, and year): Sept 4 1864

7 AGE: Years 62 Months 4 Days 10 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Plumber

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town)

(State or country) Annarundle Co

PARENTS

10 NAME OF FATHER William Weedon

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Annarundle Co

12 MAIDEN NAME OF MOTHER Emma Hyde

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Annarundle Co

14 Informant Hyde Weedon

(Address) E. Oliver St

15 Filed JAN 17 1927 19 C. HARRISON JONES M. D. Registrar

by LK

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 10 1926 to Jan 14 1926

that I last saw him alive on Jan 14 1926

and that death occurred, on the date stated above, at 1 P M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Cardio Renal Disease

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. Addison Jones M. D.

Jan 15 1927 (Address) 1540 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cemetery — Date of Burial: Jan 19 1927

20 UNDERTAKER: Robt J Turner Sons — ADDRESS 1 Broadway

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17983

## CERTIFICATE OF DEATH.

57

E 17983

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1806 N. Bond St. 8-17 Ward)

2-FULL NAME Annie Meyer

(a) RESIDENCE NO. 1806 N. Bond St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced ~~Husband~~ of (or) WIFE of Chas. C. Meyer

6 DATE OF BIRTH (month, day and year) Oct. 11th, 1860

7 AGE: Years 66 | Months 3 | Days 3 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House-work

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Virginia

PARENTS

10 NAME OF FATHER Benj. Middleton

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Virginia Fairfax

13 BIRTHPLACE OF MOTHER (City or town):

(State or country) Virginia

14 Informant Samuel Simms

(Address) 1806 N. Bond St.

Filed JAN 17 1927 HAMPTON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15th 1927

17 I HEREBY CERTIFY, That I attended deceased from 1/12 19 27, to 1-15 19 27, that I last saw h[illegible] alive on 1/14 19 27, and that death occurred, on the date stated above, at 5 30 m.

The CAUSE OF DEATH* was as follows: Pleurisy Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. Frazier, M. D.

1/16, 19 (Address) Fayette and Gay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: National Cemetery — Date of Burial 1/18 1927

UNDERTAKER: E. J. Fanning & Son — ADDRESS 1938 E. Lafayette Ave.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

90

E 17984

1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

E 17984

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1325 Madison Ave St. 11-24 WARD)

2-FULL NAME Charles Hann

(a) RESIDENCE No 1325 Madison Ave St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 81 yrs mos ds How long in U. S., if of foreign birth? yrs mos ds

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs Charles Hann

6 DATE OF BIRTH (month, day, and year): Feb 26 1846

7 AGE: Years 81 Months Days If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Jacob Hann

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: Julia Linne

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: Summer M. Hann

(Address) 2 Suncrest Road Roland

Filed JAN 17 1927 C. HAMPSON JONES, M. D. Registrar

By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): January 15 27

17 I HEREBY CERTIFY, That I attended deceased from Jan 13, 1927, to Jan 15, 1927, that I last saw him alive on Jan 15, 1927, and that death occurred, on the date stated above, at 11 p m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart
Pulmonary Oedema

(duration) yrs mos 2 ds

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) A. C Smith, M. D.

Jan 16 1927 (Address) 4509 Liberty Hgts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem

DATE OF BURIAL: Jan 18 1927

20 UNDERTAKER: Henry H Jenkins & Sons Co

ADDRESS: Reisterstown Rd & Belvedere Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 17985

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

101-001

E 17985

1-PLACE OF DEATH St. Josephs Hospital. REGISTERED NO.

CITY OF BALTIMORE: (No. 27-41 ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eleanor Hayman

(a) RESIDENCE NO. 204 Grindon Ave ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced (or) WIFE of John L. Hayman

6 DATE OF BIRTH (month, day, and year) Oct. 28- 1873

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 53, | 2. | 17 | |

8 OCCUPATION OF DECEASED

637

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer Housewife

9 BIRTHPLACE (city or town) (State or country) Indiana

PARENTS

10 NAME OF FATHER John E. Ammeb.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Delaware

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) John L. Hayman. 204 Grindon Ave

15 Filed ..... 19 ..... HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14 1927.

17 I HEREBY CERTIFY, That I attended deceased from Jan. 10, 1927. to Jan. 14, 1927 that I last saw her alive on Jan. 14, 1927 and that death occurred, on the date stated above, at 5 5 20 P.M.

The CAUSE OF DEATH* was as follows:

Cholecystitis & Cholelithiasis.

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Fever Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Hospital.

Did an operation precede death? Yes Date of 1-11-27

Was there an autopsy? No Mineral gate Street

What test confirmed diagnosis? Clinical

(Signed) B.L. McNally M. D.

, 19 (Address) St. Josephs Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Linden Park Cem. DATE OF BURIAL Jan 18 1927

20 UNDERTAKER Josiah Syfer ADDRESS 1600 W. Pratt

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JAN 1927

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17986 — 001 — E 17986

## CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH St Joseph's Hospital

CITY OF BALTIMORE: (No.) Caroline & Oliver ST., 9-17 WARD) 122

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Hulseman

(a) RESIDENCE No. Glendale. Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): ~~Divorced~~.

5a If married, widowed, or divorced ~~HUSBAND of or WIFE of~~: Louis Singld

6 DATE OF BIRTH (month, day, and year): Oct 28 — 1883

7 AGE — Years: 43 — Months: 3 — Days: 22 — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: Chas F. Hulseman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary Barthol

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland.

14 Informant: Mrs Mary Hulseman

(Address) 3717 Maine Ave Montebello

15 Filed JAN 17 1927 HAMPSON, M. D., Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 15 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1927, to Jan. 15, 1927,

that I last saw him alive on Jan. 15, 1927,

and that death occurred, on the date stated above, at 10: a. m.

The CAUSE OF DEATH* was as follows:

cirrhosis of liver

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? No. Date of

Was there an autopsy? None

What test confirmed diagnosis? clinical

(Signed) Clement K. Bowers, M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oakland Cemetery — DATE OF BURIAL: Jan. 18 1927

20 UNDERTAKER: Josiah Syfer — ADDRESS: 1600 N. North Ave

Spec.—1-10-21 M&T 1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 17987
1-PLACE OF DEATH

90 E 17987
REGISTERED NO.

CITY OF BALTIMORE: (No. 1903 Wheeler Ave St. 1568 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wallace Frisk Cunningham

(a) RESIDENCE No. 1903 Wheeler Ave St. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced
HUSBAND of (or) ~~WIFE of~~ Rebecca E Cunningham

6 DATE OF BIRTH (month, day, and year) Sept-4-1847

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 79 | 4 | 12 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stair Builder,
(b) General nature of industry, business, or establishment in which employed (or employer) 015
(c) Name of employer 9

9 BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS
10 NAME OF FATHER Elijah Cunningham
11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown.
12 MAIDEN NAME OF MOTHER Sarah Jerley
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant Chas H. Cunningham
(Address) 1903 Wheeler Ave

15 Filed JAN 17 1927 HOWARD JONES, M. D. Registrar
Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 16. 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1926 to Jan 16 1927.
That I last saw ~~him~~ alive on Jan. 15. 1927,
and that death occurred, on the date stated above, at 3. a. m.

The CAUSE OF DEATH* was as follows:
Uraemia. Nephritis.

(duration) 3 yrs. mos ds.
CONTRIBUTORY (Secondary) Cardiac dilatation
(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Albuminuria & Casts
(Signed) J. M. Lampesin M. D.
1927 (Address) 826 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Greenmount DATE OF BURIAL
St Marys Cemetery Jan. 19 1927

20 UNDERTAKER ADDRESS
D. Josiah Ryker. 1600 N Howard Ave

Spec.—12 9 25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

38 E 17988

## E 17988

## CERTIFICATE OF DEATH.

REGISTERED NO. 15-65

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. [illegible] Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emory J. Pearson

(a) RESIDENCE NO. 2310 Montgomery Road St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | Colored | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1856

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 71 70 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer do

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Joe Pearson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Julia ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Hospital records

(Address)

15 Filed JAN 7 1927 19 Per Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 14, 1927

17

I HEREBY CERTIFY, That I attended deceased from Dec. 22 19 26, to Jan. 14 19 27,

that I last saw h[illegible] alive on Jan. 14 19 27,

and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis Syphilis

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. E. Gatins, M. D.

1-15 19 27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Date of Burial 1/17/1927

20 UNDERTAKER Jos. Jos. H. Cotland ADDRESS 1631 Druid Hill

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

Wejay Bundara.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17989 — 57 — E 17989

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2215 (St.) Madison (Ward) 15-59

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wejay Bundara

(a) RESIDENCE NO. 2215 ST. Madison WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | Colored | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hannah Bundara

6 DATE OF BIRTH (month, day, and year) April 22-1882

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs or ....min. |
|---|---|---|---|---|
| | 44 | 9 | 23 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butler

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. Va. Sandy Celyan

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hannah Bundara (Address) 2215 Madison Ave

15 Filed JAN 17 1927, 19.. C. HERBERT JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/16 1927

17 I HEREBY CERTIFY, That I attended deceased from 8/7, 1926, to 1/16, 1927.

that I last saw h[illegible] alive on 1/16, 1927

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

Carcinoma Antrum

(duration) yrs. 5 mos 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jno. F. Butler, M. D.

1/16, 1927 (Address) 2149 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL 1/19/1927

20 UNDERTAKER Mrs. Geo. R. Holland — ADDRESS 1631 Druid Hill Ave

S. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 17990

179

E 17990

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2nd General Hospital St., 12-19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen Darsey

(a) RESIDENCE NO. 2019 Oak St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | Colored | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ———

6 DATE OF BIRTH (month, day, and year) Sept 24, 1922

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 4 | 3 | 20 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child, pd

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town)

(State or country) Balto md

PARENTS

10 NAME OF FATHER Roosevelt Dorsey

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Winston N. C.

12 MAIDEN NAME OF MOTHER Sadie Buchanan

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) N. C.

14 Informant Mrs Daisy Patterson

(Address) 2019 Oak St.

JAN 17 1927 HAMPSON JONES, M.D.

Registrar

Per

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

2nd degree burns of body.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nothing caught fire from coal oil lamp.

(duration) yrs. mos. ds.

(Signed) J. T. Kennedy M. D. (Coroner)

Jan. 15, 1927 (Address) 2802 Edmondson Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemtary — Date of Burial Jan 17 19 27

UNDERTAKER Thomas E. Kelson — ADDRESS 1303 Pressman

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17991

## CERTIFICATE OF DEATH.

100-001

E 17991

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Provident Hosp. St., 18-26 Ward)

2-FULL NAME Frances Williams

(a) RESIDENCE NO. 112 Lombard St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | colored | single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1925

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 2 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER James Williams

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Shackelford

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md. East

14 Informant Mrs. Lee Williams

(Address) 112 Lombard St.

FILED JAN 17 1927 H. HANSON JONES, M. D. Registrar

Per [illegible]

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 14, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of the breast

(duration) yrs. mos. ds.

(Signed) [illegible], M. D.
(Coroner)

1927 (Address) 112 Lombard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Lebanon Cem Date of Burial Jan 17 1927

20 UNDERTAKER Leonard Wheeler ADDRESS 2 Smyth Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17992 E 17992

## CERTIFICATE OF DEATH.

REGISTERED NO. 100

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1742 E Lombard St 2-4 WARD)

2-FULL NAME Carrie Genovese

(a) RESIDENCE NO. 1742 E Lombard St WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | W | Infant |

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of)

6 DATE OF BIRTH (month, day, and year) June 22 1926

| 7 AGE Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|
| | 4 | 25 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Joseph Genovese

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Minnie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Joseph Genovese (Address) 1742 E Lombard

15 Filed JAN 17 1927 C. HAMPTON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 15 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1927, to Jan 15, 1927, that I last saw h[illegible] alive on Jan 15, 1927, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Acute Bronco Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph L. Salvatore M. D.

17, 1927 (Address) 16 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Jan 17 1927

20 UNDERTAKER D. Wendell Diffendal Son — ADDRESS 378 Monr

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 17993

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 17993

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 1025 Greenmount St. 10-E Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Kate Dunn

(a) RESIDENCE NO. 1025 Greenmount Ave St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | white | widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Dunn

6 DATE OF BIRTH (month, day, and year) Dec 3/1852

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 74 | 1 | 11 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Ireland

PARENTS

10 NAME OF FATHER James Kelly

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Ann Guff

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Irelnad

14 Informant James McDonald (Nephew)

(Address) 1025 Greenmount Ave

15 Filed_____, 19__ C. HAMPSON JONES, M. D. Registrar

JAN 17 1927

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 Jan 14/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) Enquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Cardiac Failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

(Signed) J. H. Bacon M. D.
(Coroner)

1/17/27 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cemetery Yard Date of Burial Jan 18, 1927

20 UNDERTAKER Elmer W. Conklin ADDRESS 924 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 17994

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 E 17994

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1404 Lemon St. 19-27 (Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Plater

(a) RESIDENCE NO. 1404 Lemon St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | Colored | Widow |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| About | 68 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Nancy Jefferson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore

14 Informant John Plater

(Address) 1404 Lemon St

Filed JAN 17 1927 Per C. HARRISON JONES, M.D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15th 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, and from Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia (duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) General Debility (duration) yrs. mos. ds.

(Signed) Thos. B. Fenton M. D. (Coroner)

Jan 17th 1927 (Address) Curtis Bay, Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem Date of Burial Jan 17th 1927

UNDERTAKER C. Jones ADDRESS W. S. Edmondson St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 17995

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17995

## CERTIFICATE OF DEATH.

REGISTERED NO. 161

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 424 W. Cross St.) (WARD) 25-12

2-FULL NAME Infant of Alton Tuttle & Emma Grant 6 hrs old

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. 1 Russell st WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. 2 ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | Col | Infant |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) Jan 11-1927

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | no | no | 4 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Alton Tuttle

11 BIRTHPLACE OF FATHER (city or town) (State or country) D C.

12 MAIDEN NAME OF MOTHER Emma Grant

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Emma Grant

(Address) 1 Russell St

Filed JAN 17 1927 19 C. HAMPSON JONES, M.D. Registrar

Per R H

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1927, to Jan 10, 1927, that I last saw h[illegible] alive on Jan 12, 1927, and that death occurred, on the date stated above, at 11 p. m.

The CAUSE OF DEATH* was as follows:

Premature Birth 6 hrs

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? finger prints on file

(Signed) Rexford M. D.

Jan 16 1927 (Address) Lakeland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Mount Calvary | Jan 17 1927 |

20 UNDERTAKER Mrs R A Elliott ADDRESS 1723 Lakeland Av

G. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 17996

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17996

## CERTIFICATE OF DEATH.

REGISTERED NO. 57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1104 Riggs Street (St.) 16-23 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Deborah Chaney

(a) RESIDENCE NO. 1104 Riggs Street (St.) WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Robert Chaney

6 DATE OF BIRTH (month, day, and year): 1848

7 AGE: 68 Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore City

PARENTS

10 NAME OF FATHER: Daniel Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): Kentucky

12 MAIDEN NAME OF MOTHER: Cushwood

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant (Address): Margaret Palmer 1104 Riggs Street

15 Filed JAN 17 1927

C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 14th 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1926 to Jan. 14th 1927, that I last saw h[illegible] alive on Jan 13th 1927, and that death occurred, on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Elliott, M. D.

(Address) 1104 Riggs St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bank Hill Cemetery

DATE OF BURIAL: 1/19/27

20 UNDERTAKER: Mrs. R. A. Elliott

ADDRESS: 728

WARNING RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 17997

REGISTERED NO. 90 E 17997

1-PLACE OF DEATH

City of BALTIMORE: (No. ____ St., 7-11 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Willie Jones

(a) RESIDENCE NO. 510 East St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: unknown

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE: Years 51; Months; Days; IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Robert Jones

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Virginia

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): ?

14 Informant:

(Address): Records

15 Filed ..... 19 .....

JAN 7 1927 C. HARRISON JONES, M. D. Registrar

Per ____

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): January 14 1927

17 I HEREBY CERTIFY, That I attended deceased from October 29, 1926, to January 14, 1927, that I last saw him alive on January 13, 1927, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Arterial Sclerosis

Chronic Myocarditis ....

(duration) ? yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted (if not at place of death)

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? general & laboratory.

(Signed) C. Wagner Smith, M. D.

Jan, 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary Date of Burial 1/19/27

20 UNDERTAKER: Mrs. R. A. Elliott ADDRESS 1725 Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.–7-17-26—A Co.—200 Bks.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17998

## CERTIFICATE OF DEATH

× 146

E 17998

1-PLACE OF DEATH University Hospital REGISTERED NO.

City of BALTIMORE: (No. 4-30 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jeanette Vollmerhausen

(a) RESIDENCE NO. Jessups, md St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Conrad Vollmerhausen

6 DATE OF BIRTH (month, day, and year) centenn.

| 7 AGE | Years | Months | Days | IF LESS than 1 day ...hrs. or ...min.. |
|---|---|---|---|---|
| | 32 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Guilford

(State or country) Md

PARENTS

10 NAME OF FATHER Wm. E. Carr

11 BIRTHPLACE OF FATHER (City or town)

(State or country) md

12 MAIDEN NAME OF MOTHER Jeanette Carr

13 BIRTHPLACE OF MOTHER (City or town)

(State or country) Md

14 Informant University Hosp.

(Address) Balto Md

15 Filed JAN 17 1927 16 H. HARRISON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 1/17/27

17 I HEREBY CERTIFY, That I attended deceased from 1/15/27, 19 ... to 1/17/27, 19 ...

that I last saw her alive on 1/17/27, 19 ...

and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Toxemia

Streptococcus (?) Septicemia

(duration) ... yrs. ... mos 4 ds.

CONTRIBUTORY Cellulitis of right (Secondary) shoulder

(doration) ... yrs. ... mos 6 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? yes Data of 1/16/27

Was there an autopsy? no

What test confirmed diagnosis? Blood culture being

(Signed) J. S. Winstead, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Soicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Md — Date of Burial 1/20/27

20 UNDERTAKER Geo. E. Enoch — ADDRESS Laurel Md

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 17999

129

E 17999

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1110 Eighth St. Morrell Park (St.) (Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME John T. Mix

(a) RESIDENCE NO. 1110 Eighth St. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna M. Mix

6 DATE OF BIRTH (month, day, and year): May 3, 1854

7 AGE: Years 72 | Months 8 | Days 12 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Woodworker

(b) General nature of industry, business, or establishment in which employed (or employer): Knabe Piano Co.

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: John T. Mix

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Germany.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: Anna M. Mix

(Address): 1110 Eighth St. Morrell Pk

15 Filed JAN 17 1927 HARRISON JONES, M.D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 15th 1927

17 I HEREBY CERTIFY, That I attended deceased from January 1, 1927, to January 15, 1927

that I last saw h.. alive on January 15, 1927

and that death occurred, on the date stated above, at 10.30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) .....yrs. .....mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. ..... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

Jan 15 1927 (Address) 332 Bank Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cem. Date of Burial: Jan 18 1927.

20 UNDERTAKER: Jas. Mus. John W. Teufel & Son ADDRESS: 901 W. Fayette

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18000

## CERTIFICATE OF DEATH

11002

E 18000

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 28 N. East Ave. 6-11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy E. Comeau.

(a) RESIDENCE NO. 28 N. East Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 28-1926

7 AGE — Years: — Months: 5 Days: 17

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md.

PARENTS

10 NAME OF FATHER: Edward Comeau

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Nova Scotia

12 MAIDEN NAME OF MOTHER: Mary Wohlford

13 BIRTHPLACE OF MOTHER (city or town): Balt.

(State or country): Md.

14 Informant: Edward Comeau

(Address): 3707 Lough St.

Filed JAN 17 1927, 19 C. HAMPSON JONES, M. D. Registrar

Per R.M.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 15-1927

17 I HEREBY CERTIFY, That I attended deceased from January 13, 1927 to January 15, 1927

that I last saw her alive on January 15, 1927

and that death occurred, on the date stated above, at 11:55 P. m.

The CAUSE OF DEATH* was as follows:

Influenzal Meningitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): La Grippe

(duration) yrs. mos. 14 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) J. B. Ln. B. Bronushas, M. D.

1-16 19 27 (Address) 3037 O'Donnell St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart. Cem.

Date of Burial: Jan 17 1927

20 UNDERTAKER: Lilly & Zeiler

ADDRESS: 403 S. Wolfe St.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

# E 18001

CERTIFICATE OF DEATH.

# E 18001

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 115 S. Payson St. 20-67 Ward)

2-FULL NAME Annie C. Wannenwetsch

(a) RESIDENCE NO. 115 S Payson St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo. R. Wannenwetsch

6 DATE OF BIRTH (month, day, and year): Dec. 8-1860

7 AGE: Years 66 | Months 1 | Days 6 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): At home

(c) Name of employer

9 BIRTHPLACE (city or town): Balto.

(State or country): Md

PARENTS

10 NAME OF FATHER: Bruckner

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Untgroun

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: William Klemmer

(Address): 10 E. Lexington St

15 Filed: JAN 17 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): January 14 1927

17 I HEREBY CERTIFY, That I attended deceased from June 1926, to Jan 14, 1927

that I last saw h.e alive on Jan 14, 1927

and that death occurred, on the date stated above, at 9:10 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

Hypertrophy (duration) yrs. 8? mos. ds.

If where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) M. J. Hanna, M. D.

1/16, 1927 (Address) 1522 N. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery Date of Burial Jan 19 1927

20 UNDERTAKER: George L. Schwab & Son

ADDRESS

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. -7-17-26—A Co.—200 Bks.

E 18002

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

90

E 18002

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. St Agnes Hospital St. 2870 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Virginia Gerber.

(a) RESIDENCE NO. 3769 Roseuth Pl. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles P. Gerber

6 DATE OF BIRTH (month, day, and year): Aug. 5 - 1891

7 AGE — Years: 35 — Months: 5 — Days: 10 — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): At home

(c) Name of employer

9 BIRTHPLACE (city or town): Balto.

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Louis W. Atkins

11 BIRTHPLACE OF FATHER (City or town): Dec'd know

(State or country): Md

12 MAIDEN NAME OF MOTHER: Ida Sattler

13 BIRTHPLACE OF MOTHER (city or town): Md

(State or country)

14 Informant: Mrs. Ida Atkins.

(Address) 3769 Roseuth Pl.

15 Filed JAN 17 1927 C. HAMPSON JONES, M. D. Registrar

Per Reg.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1-15- 1927

17 I HEREBY CERTIFY, That I attended deceased from 1-9 1927 to 1-15- 1927

that I last saw h alive on 1-15- 1927

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Pancarditis and

septicaemia (duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood culture

(Signed) J. Thurston Hunter M. D.

(Address) St. Agnes' Hospital

1/15 1927

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — Date of Burial: Jan 18 1927

20 UNDERTAKER: George L. Schwab — ADDRESS: 3401 Eutaw Pl.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18003

## CERTIFICATE OF DEATH.

162

E 18003

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 127 W. Lanvale St. 11-20 Ward)

2-FULL NAME Baby Johnson

(a) RESIDENCE NO. 127 W. Lanvale St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | colored | single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 24, 1926

| 7 AGE | Years | Months | Days | IF LESS than 1 day 1 hrs. or min. |
|---|---|---|---|---|
| | | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Albert Johnson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Mary Johnson

(Address) 127 W. Lanvale St.

15 Filed 19

JAN 17 1927 C. HAMPSON JONES, M. D.

Per

Registrar

4950

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 24, 192 6

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fatal Pneumonia (Autopsy)

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) C. Hampson Jones M. D.
(Coroner)

Jan 19, 1927 (Address) 2502 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the state yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

HOPKINS HOSPITAL

Commissioner Health.

MORGUE

Per Wm. E. WOODALL

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18004

## CERTIFICATE OF DEATH.

101-001

E 18004

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 766 W Mulberry St. 17-26 Ward)

2-FULL NAME Annie Smith

(a) RESIDENCE NO. 766 W Mulberry St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: not known

6 DATE OF BIRTH (month, day, and year): 5 21

7 AGE — Years: 50 — Months — Days — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Florist

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Md.

(State or country)

PARENTS

10 NAME OF FATHER: Nat Duncan

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Md

12 MAIDEN NAME OF MOTHER: Nat Duncan

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Md

14 Informant:

(Address)

Filed 19 Registrar

C. HAMPSON JONES, M. D.

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/11/ 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Nat (duration) 1 day yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Samuel T. Darker M. D.

(Coroner)

19 7 (Address) 325 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

Commissioner Health.

JAN 27 1927

THE MORGUE

Per [illegible]

JAN 17 1927

Dr.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 18005

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 18005

REGISTERED NO. 199

1-PLACE OF DEATH

City of BALTIMORE: (No. Hopkins Hospital St., 3-5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Alford

(a) RESIDENCE NO. 131 Albemarle St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | col | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Alford

6 DATE OF BIRTH (month, day, and year)

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 38 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Unknown

PARENTS

10 NAME OF FATHER "

11 BIRTHPLACE OF FATHER (city or town)

(State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) "

14 Informant Police Dept

(Address)

JAN 7 1927 19 C. HAMPSON JONES, M. D.

Per Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Paralysis-severed spinal cord.
Fell to floor in aflight.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. M. Collins, M. D. (Coroner)

1-15-19 27 (Address) 505 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

JOHNS HOPKINS HOSPITAL
Commissioner Health

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 18006

E 18006

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. (T. B.) 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Morrow

(a) RESIDENCE NO. Front and Fayette sts. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1851

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| 16 | 75 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town)

(State or country) Ireland

PARENTS

10 NAME OF FATHER James R. Morrow

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Alice Carter

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Hospital Records

(Address)

15 JAN 7 1927 C. HARPSON JONES, M. D.

PROG Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

January 15, 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 15, 1926 to Jan. 15, 1927, that I last saw him alive on Jan. 15, 1927, and that death occurred, on the date stated above, at 12.30 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis
Tuberculous epididymitis
(duration) Unknown yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

1-15-1927 (Address) Baltimore City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL Date of Burial 12

20 UNDERTAKER ADDRESS

Commissioner Health. JAN 17 1927

JAN 17 1927

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 18007 ✓ 124 E 18007

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home & Infirmary St., 4 (Ward)

2-FULL NAME Frank Kilkoski

(a) RESIDENCE NO. 123 S. Castle St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: ~~Female~~ Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of / WIFE of: Victoria

6 DATE OF BIRTH (month, day, and year): Dec 4 - 1865

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 61 | 1 | 12 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Processor Prosser

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Poland.

PARENTS

10 NAME OF FATHER Hendry

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Kilkoski

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Victoria Kilkowski

(Address) 123 S castle

15 Filed JAN 17 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

January 16, 1927

17 I HEREBY CERTIFY, That I attended deceased from January 1, 1927, to January 16, 1927, that I last saw him alive on January 16, 1927, and that death occurred, on the date stated above, at 12 00 P m.

The CAUSE OF DEATH* was as follows:

Terminal Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Arteriosclerosis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Samuel H. Norwood, M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Date of Burial Jan 19 1927

20 UNDERTAKER: F. W. Ozazenski ADDRESS 1930 Eastern Ave.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18008 E 18008

## CERTIFICATE OF DEATH.

REGISTERED NO. 179

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Mid Genl Hospt ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clarence Hamilton

(a) RESIDENCE No. 512 Bloomfield St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Dec 19 1890

7 AGE: Years 36 | Months | Days 26 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer: Balto Tube

040

9 BIRTHPLACE (city or town) (State or country): Christiansburg

PARENTS

10 NAME OF FATHER: Joseph Hamilton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Christiansburg

12 MAIDEN NAME OF MOTHER: Mary Cotton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Christiansburg

14 Informant: Clarence Hamilton
(Address): 512 Bloomfield St

15 Filed OCT 7 1927, 192 C. HAMPSON JONES, M. D. Registrar
Per

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 14 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

2nd degree burns of body (accidental)

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Pellagra extreme

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy, M. D. (Coroner.)

Jan 14, 192 (Address) 20 Mulberry St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Christiansburg Va. DATE OF BURIAL: 1/16 192 7

20 UNDERTAKER: Clarence Hamilton ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18009 | CERTIFICATE OF DEATH. | 129 E 18009

23-31

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1423 S. Charles St. Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Amelia V. Taylor.

(a) RESIDENCE NO. 1423 S. Charles St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 3 mos. 30 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female,

4 Color or Race: White,

5 Single, Married, Widowed, or Divorced, (write the word): Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William H. Taylor.

6 DATE OF BIRTH (month, day, and year): Sept, 17, 1850.

7 AGE — Years: 76, Months: 3, Days: 30. IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Mayers Dept.

(b) General nature of industry, business, or establishment in which employed (or employer): Store., Saleslady.

(c) Name of employer

9 BIRTHPLACE (city or town): Balto.

(State or country): Md.

PARENTS

10 NAME OF FATHER: Henry Lambright.

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Germany.

12 MAIDEN NAME OF MOTHER: Caroline-------

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany.

14 Informant: William Lambright (Brother).

(Address) 1423 S. Charles Street.

Filed JAN 17 1927 C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

January 16th 1927

17 I HEREBY CERTIFY, That I attended deceased from December 29 1926 to Jan 16th 1927

that I last saw h.. alive on Jan 16th 1927

and that death occurred, on the date stated above, at 2.45 P m.

The CAUSE OF DEATH* was as follows:

Uraemic Coma

Uraemia

(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary) Intestinal Nephritis Arteriosclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Joseph B Saunders, M. D.

19 (Address) 719 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Louden Pk. Bm. Date of Burial Jan 19, 19 27

20 UNDERTAKER: A. Howard Evans ADDRESS 56 Eutaw

CAUTION.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 18010

REGISTERED NO. E 18010

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1424 S. Charles St. Ward 23-31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margareth Miller.

(a) RESIDENCE NO. 1424 S. Charles St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if of foreign birth? 77 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female. | White. | Widowed. |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis B. Miller.

6 DATE OF BIRTH (month, day, and year) Nov, 3, 1843.

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 83, | 2, | 12. | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany.

PARENTS

10 NAME OF FATHER -------- Reidel.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER ----- Stierhoff.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany.

14 Informant Harry L. Miller.

(Address) 1424 S. Charles St.

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15, 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 25 1926, to Jan 1 1927, that I last saw h... alive on Jan 1 1927, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows: Cardiac failure

(duration) ... yrs. 1 mos. 15 ds.

CONTRIBUTORY (Secondary) Influenza, Pneumonia

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) ... M. D.

, 19 (Address) 1240 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. Date of Burial Jan 19 1927

20 UNDERTAKER J. Edward Evans & Son ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18011

E 18011

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home & Infirmary St. 6-9 Ward)

2-FULL NAME Mrs Margaret Carr

(a) RESIDENCE NO. Fulleton, Md St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? 54 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Harry Carr

6 DATE OF BIRTH (month, day, and year): September 28 1872

7 AGE — Years: 54. Months: 3 Days: 17 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer): Wife

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Peter Rodgers

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Margaretta Dayn

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant (Address) Harry Carr 25 N. Edmondson Ave

C. HAMPSON JONES, M. D. Registrar

JAN 17 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 Jan 15, 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 13, 1927, to Jan 15, 1927, that I last saw h[illegible] alive on Jan 15, 1927, and that death occurred, on the date stated above, at 5 40 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Failure

Chronic Myocarditis

(Duration) yrs. mos. ds.

CONTRIBUTORY Lobar Pneumonia (Secondary)

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Vernon L Howard, M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery Date of Burial: Jan 18 1927.

20 UNDERTAKER: Kendall & Hupfel ADDRESS: 300 N Edmondson

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18012

## CERTIFICATE OF DEATH

129

E 18012

1-PLACE OF DEATH

REGISTERED NO. 20-69

City of BALTIMORE: (No. 2504 Lonsdale Ave St.) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ada A Cox.

(a) RESIDENCE NO. 2504 Lonsdale Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Herbert C Cox

6 DATE OF BIRTH (month, day, and year): April 1, 1903

7 AGE: Years 23 Months 9 Days 15 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Bath Me

PARENTS

10 NAME OF FATHER: Robert L Price

11 BIRTHPLACE OF FATHER (City or town) (State or country): Wash. D C

12 MAIDEN NAME OF MOTHER: Ada Gibson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Wash. D C

14 Informant: Herbert C Cox

(Address): 2504 Lonsdale Ave

15 Filed JAN 17 1927

16 C. HAMPSON JONES, M. D.

Per ORD Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

January 16 - 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 12, 1927, to Jan 16, 1927, that I last saw h alive on Jan 16, 1927, and that death occurred, on the date stated above, at 8 40 P m.

The CAUSE OF DEATH* was as follows:

Uraemia,

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic Parenchymatous Nephritis

(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis and ...

(Signed) McBoone and Hood, M. D.

1/17, 1927 (Address) 626 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Lowe Cem Jan 19 | Date of Burial 1927

20 UNDERTAKER: W. A. Cook ADDRESS 502 E Monroe

R.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

Wunder

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18013

CERTIFICATE OF DEATH.

118-001

E 18013

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Baltimore Gen. Hosp (WARD) 20-69

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Lorole K Wunder

(a) RESIDENCE NO. 253 E Lanvale St (WARD)

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 10 1883

7 AGE: Years 43 Months 7 Days 10 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER Richard Simonds

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER Laura Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): West Baltimore Hosp Reads

15 Filed 1/17 1927 19

C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/17 1927

17 I HEREBY CERTIFY, That I attended deceased from 1/13 1927 to 1/17 1927

that I last saw her alive on 1/17 1927

and that death occurred, on the date stated above, at 1:45 a m.

The CAUSE OF DEATH* was as follows:

Strangulated ventral hernia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 1/13/27

Was there an autopsy? no

What test confirmed diagnosis? Clinical history

(Signed) Orvus Swann, M. D.

1/17, 1927 (Address) West Balt. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: Jan 19 1927

20 UNDERTAKER: Wm Cook

ADDRESS: 317 Church

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DURATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

Dr Dows, 824 N Fulton Ave

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 18014 90 E 18014

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3011 Westwood Ave St., 15-67 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eunice M Bailey

(a) RESIDENCE NO. 3011 Westwood Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Roger G Bailey

6 DATE OF BIRTH (month, day, and year): Nov 19, 1888

7 AGE: Years 38 Months 1 Days 27 IF LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country): Md

PARENTS

10 NAME OF FATHER: George L Hurley

11 BIRTHPLACE OF FATHER (City or town): Balto

(State or country): Md

12 MAIDEN NAME OF MOTHER: Mary A Lundy

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country): Md

14 Informant: Roger G Bailey

(Address): 3011 Westwood Ave

15 Filed ____ 19 ____ C. HAMPSON JONES M.D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 16 1927 Jan. 16. 27

17 I HEREBY CERTIFY, That I attended deceased from four years, 19 ____ to date of death, 19 ____ that I last saw h- alive on Jan 16, 19 27 and that death occurred, on the date stated above, at 11:45 a. m.

The CAUSE OF DEATH* was as follows: Mitral heart Insufficiency

(duration) 2 yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted

If not at place of death? ____

Did an operation precede death? ____ Date of ____

Was there an autopsy? ____

What test confirmed diagnosis? ____

(Signed) Stanley Sutton, M. D.

Jany 17, 27 (Address) 824 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem Date of Burial Jan 19 1927

20 UNDERTAKER: H. Cook ADDRESS 307 Hartley

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18015

E 18015

## CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

City of BALTIMORE: (No.) 4601 Liberty Hts Ave St., 28-6th Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph A Hagary Sr.

(a) Residence No. 4601 Liberty Hts Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. ✓ mos. ✓ ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widower

5a-If married, widowed, or ~~divorced~~ HUSBAND of (or) ~~WIFE of~~ Louisa V.

6-DATE OF BIRTH (month, day and year) Apr. 23-1847

7-AGE. 79 yrs. 8 mos. 23 ds. If LESS than 1 day, ✓ hrs. or ✓ min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country). Ireland

PARENTS.

10-NAME OF FATHER. David Hagary.

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ireland.

12-MAIDEN NAME OF MOTHER. Ellen McCracken

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland.

14- (Informant) Mrs. Geo. C. Neumann

(Address) 700 Fulton Ave

15- Filed JAN 7 1927 C. HAMPSON JONES, M. D. Registrar.

N1

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jany 16 - 27

17- I HEREBY CERTIFY, That I attended deceased from January 13 1927 to Jany 16 1927

that I last saw h. living on Jany 15 1927

and that death occurred, on the date stated above, at 3.50a m.

The CAUSE OF DEATH* was as follows:

Bronchitis Acute

(Duration) ✓ yrs. ✓ mos. 3 ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) ✓ yrs. 1 mos. ✓ ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis? Clinical -

(Signed) George C. Neumann M. D

1/16 1927 (Address) 700 Fulton Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

| 19-PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL. |
|---|---|
| Druid Ridge Cem | Jan 18 1927 |
| 20-UNDERTAKER. | ADDRESS |
| Geo. C. Smith | Baltimore |

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSES OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18016 E 18016

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH 6 N. Bond St. 5-8 31 REGISTERED NO.

CITY OF BALTIMORE: (No. ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Frances Stewart

(a) RESIDENCE NO. 6 N. Bond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | W | widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James A. Stewart

6 DATE OF BIRTH (month, day, and year) April 8, 1880

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 46 | 9 | 9 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) — 037

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John Hennebovey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Matilda Gettinger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Anna Hoppey

(Address) 6 N. Bond St

15 Filed JAN 17 1927, 19 C. HAMPSON JONES, M. D. Registrar

Per RKH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug. 12 1926 to Jan 17 1927

that I last saw her alive on Jan 17 1927

and that death occurred, on the date stated above, at 6.35 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? positive sputum

(Signed) L. C. Sobhad, M. D.

, 19 (Address) 747 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Saint Vincents Cem. DATE OF BURIAL Jan. 20 1927

20 UNDERTAKER George J. Smith ADDRESS 1532 Watkins

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

91-22

E 18017

## CERTIFICATE OF DEATH

E 18017

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 4 Homestead St., 26-41 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie T. Owens

(a) RESIDENCE NO. 4 Homestead St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec 10, 1858

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 68 | 1 | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of indostry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Dames Quarters Md

PARENTS

10 NAME OF FATHER: John H Hughes

11 BIRTHPLACE OF FATHER (City or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Fannie Shores

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Mrs Charles J Thomas

(Address): 4 Homestead Ave

15 1-17-1927 C. HAMPSON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 16 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 2, 1926, to Jan 16, 1927, that I last saw her alive on Jan 16, 1927, and that death occurred, on the date stated above, at 10 30 P.m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis (Cerebral)

(duration) 1 yrs. mos. da.

CONTRIBUTORY (Secondary): Coma

(duration) yrs. mos. 7 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter W Lute, M. D.

1/17, 1927 (Address) 2800 N Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dames Quarters Md — Date of Burial: Jan 19 1927

20 UNDERTAKER: George J Smith — ADDRESS 1532 Hollins

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

W25-67 E-22 mo

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 18018

REGISTERED NO. E 18018

1-PLACE OF DEATH

City of BALTIMORE: (No. 2106 Guilford St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Robert Elder

(a) RESIDENCE NO. 2106 Guilford St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of): Bertha Brown

6 DATE OF BIRTH (month, day, and year): Aug 2-879

7 AGE: Years 47 Months 5 Days 6

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter Helper

(b) General nature of industry, business, or establishment in which employed (or employer): P. Reilly

(c) Name of employer: Penn. R.R. Co.

9 BIRTHPLACE (city or town) (State or country): Penn.

PARENTS

10 NAME OF FATHER: John R. Elder

11 BIRTHPLACE OF FATHER (City or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Rebecca Macafee

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Mrs. John R. Elder 2106 Guilford Ave

15 Filed JAN 18 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 16th 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov-25 1926 to January 16th 1927

that I last saw h alive on Jan. 16th 1927

and that death occurred, on the date stated above, at 2:30 A m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

J. K. Corner, J. Thomas

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, Contracted Kidneys

(duration) 2 yrs. mos ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Symptoms

What test confirmed diagnosis?

(Signed) J. K. Corner M. D.

, 19 (Address) 532 E. 22nd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Bur.

Date of Burial 19 19

20 UNDERTAKER: H. M. Cole

ADDRESS 522 E Balto

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

90

E 18019

REGISTERED NO. E 18019

1-PLACE OF DEATH

City of BALTIMORE: (No. 1739 Orleans St. 69 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dobe Miles

(a) RESIDENCE NO. 1739 Orleans St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | Colored | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hester Miles

6 DATE OF BIRTH (month, day, and year) 1883

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|---|
| | 43 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Chase Md.

9 BIRTHPLACE (city or town) Chase Md.

(State or country)

PARENTS

10 NAME OF FATHER Peter Miles

11 BIRTHPLACE OF FATHER (City or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Peter Miles

(Address) 1739 Orleans St.

15 Filed JAN 18 1927 C. HAMPSON JONES, Registrar

Per LK

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 9, 1927, to Jan 16, 1927

that I last saw him alive on Jan 16, 1927

and that death occurred, on the date stated above, at 12-0 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular heart disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible] M. D.

1-17, 1927 (Address) 120 Augusta St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Soicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Osborn Cemetery — Date of Burial: Jan. 19 1927

UNDERTAKER: Chas. H. Johnson — ADDRESS: 461 Carlisle St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18020

## CERTIFICATE OF DEATH.

E 18020

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 614 Jarolya Ct St. 14-25 Ward)

2-FULL NAME Saml. L. Matthews

(a) RESIDENCE NO. 614 Jarolya Ct St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | Col'd | Wid |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1870

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..hrs. or ..min. |
|---|---|---|---|---|
| | 47 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Co

(State or country) Md

PARENTS

10 NAME OF FATHER Chas Matthews

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Isabella Coomes

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Mary Clarke

(Address) 1230 Ellamy

15 Filed JAN 18 1927 C. HAMPSON JONES, M. D.

Per RK Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15 19 27

17 I HEREBY CERTIFY, That I attended deceased from Nov 5 19 26, to Jan 14, 19 27, that I last saw h alive on Jan 14 19 27, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Pulm. Edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? T B Bac

(Signed) [illegible], M. D.

19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Road — Date of Burial 1/18 19 27

UNDERTAKER Samuel T Hamilton — ADDRESS 578 N Bridle

INSTRUCTIONS: Before filling out this certificate, read carefully the instructions on the back of the certificate. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 18021

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 18021

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2007 Llewellyn St.) (5-16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Whitehead

(a) RESIDENCE. No. 2007 Llewellyn ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Carrie Whitehead

6 DATE OF BIRTH (month, day, and year): 1894

7 AGE: Years 33; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Isaac Whitehead

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Elizabeth Allen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Carrie Whitehead (Address) 2007 Llewellyn St.

Filed JAN 18 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 15 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 15 . 1927 . to Jan 15 . 1927.

that I last saw him alive on Jan 15 . 1927.

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Cardiac Depression

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Thos. J. McGuigan M. D.

1-17 1927 (Address) 603 N. Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Land

DATE OF BURIAL 1/18 1927

UNDERTAKER: Samuel F. Hemsley

ADDRESS 578 N. Bridle

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

# HEALTH DEPARTMENT---CITY OF BALTIMORE

E 18022

## CERTIFICATE OF DEATH

E 18022

REGISTERED No. C 135 B-51

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2427 Madison ave St.) (WARD) B-51

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Stewart

(Residence in Baltimore: No. 2427 Madison ave St.; 75 yrs. mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widower

6-DATE OF BIRTH: Sept 20 (Month) (Day), 1844 (Year)

7-AGE: 82 yrs. 3 mos. 26 ds. If LESS than 1 day, hrs., or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: retired
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country): Ireland

PARENTS

10-NAME OF FATHER: John Stewart

11-BIRTHPLACE OF FATHER (State or country): Ireland

12-MAIDEN NAME OF MOTHER: Martha McEntire

13-BIRTHPLACE OF MOTHER (State or country): Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dr. Geo. A. Stewart

(Address) 2427 Madison Ave

15- Filed JAN 18 1927 191 REGISTRAR

Per

### MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Jan (Month) 16 (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 22, 1926, to, Jan 16 1927, that I saw h[illegible] alive on Jan 16 1927, and that death occurred, on the date stated above, at 6.10 P m.

The CAUSE OF DEATH* was as follows:

Acute Infective Nephritis

(Duration) yrs 1 mos ds.

Contributory (SECONDARY) Hypertrophied Prostate with Retention Operation Sept 11, 1927 Prostatectomy (Duration) (?) yrs mos. ds.

(Signed) Geo A Stewart M. D.

Jan 16, 1927 [Address] 2427 Madison Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park

DATE OF BURIAL: Jan 19 1927

20-UNDERTAKER: John Conistead

ADDRESS: Baltimore Md

A.S.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 18023

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 18023

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 2600 Elsinor ave ST. 15-61 WARD)

2-FULL NAME Sophia Heinziller

(a) RESIDENCE No. 2600 Elsinor ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs mos ds. How long in U. S., if not foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 25 1849

7 AGE — Years: 77 Months: 9 Days: 23 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Paul Heinziller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Sophia Schmauffer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Annie Cromwell

(Address) 2600 Elsinor Ave

15 Filed JAN 18 1927 H. HAMPTON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 17 19

17 I HEREBY CERTIFY, That I attended deceased from Jan 1925 to Jan 17 1927.

that I last saw her alive on Jan 16 1927.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cerebral Adema. and Haemaplegia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility. Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Carl L Schumpert M. D.

(Address) 2501 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Jan 19 19 27

20 UNDERTAKER: John O. Mitchell — ADDRESS: Paul V. Myers

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18024

## CERTIFICATE OF DEATH.

E 18024

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hosp St. 70 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Conrad Dahling

(a) RESIDENCE NO. 2644 Wilkins Ave St. 70th Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? 50 yrs. — mos. — ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or race: white

5 Single, Married, Widowed, or Divorced.. (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE Conrad Dahling

6 DATE OF BIRTH (month, day, and year) Jan 25th 1857

7 AGE: Years 70 69 | Months 11 | Days 21 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor

(b) General nature of industry, business, or establishment in which employed (or employer) American Tanning

(c) Name of employer Co

9 BIRTHPLACE (city or town) Germany

(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Darmmeyer

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs Marshall Lucas

(Address) 2644 Wilkins ave

JAN 18 1927

C. HAMPTON JONES, M. D.

Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Jan 16 - 27

17 I HEREBY CERTIFY, That I attended deceased from 11-11-26 to 1-16-1927.

that I last saw him alive on 1-16-27 and that death occurred, on the date stated above, at 2 45 P.M.

The CAUSE OF DEATH* was as follows:

Fracture neck femur right, decubitus

(duration) yrs. 11 mos. ds.

CONTRIBUTORY (secondary) Lumbar Bronchopneumonia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phy-findings

(Signed) Emil Schmied M. D.

, 19 (Address) Balto City Hosp

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westen Cemetery

Date of Burial: Jan 18th 1927

UNDERTAKER: E. B. Weisent

ADDRESS: 1850 N. Gilmor St

Don't should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 18025

REGISTERED NO. E 18025

1-PLACE OF DEATH

City of BALTIMORE: (No. 125 n Grant St., 425 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lennetta John

(a) RESIDENCE NO. 125 n Grant St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | W | M |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Vincent Ditone

6 DATE OF BIRTH (month, day, and year) Feb — 1916

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 9 | 11 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Penn

(State or country)

PARENTS

10 NAME OF FATHER not known

11 BIRTHPLACE OF FATHER (city or town)

(State or country) not known

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) not known

14 Informant Vincent Ditone

(Address) 125 n Grant St

15 Filed JAN 18 1927 C. HAMPSON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Cerebral Arteriosclerosis (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) not known

(duration) yrs. mos. ds.

(Signed) Samuel A Tucker M. D.

(Coroner)

, 192 7 (Address) 225 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem Date of Burial Jan 18 1927

20 UNDERTAKER H. M. Routson ADDRESS 2238 W North

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 1-10-21 M&T 1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

99-002

E 18026

## CERTIFICATE OF DEATH.

REGISTERED NO. E 18026

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1140 Washington Blvd ST., 21-29 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Griffin

(a) RESIDENCE NO. 1140 Washington Blvd ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 10 1858

7 AGE — Years: 68 | Months: 1 | Days: 6 7 | If LESS than 1 day, ..... hrs or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER William Rice

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER Ann Kund

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs Griffin (Address) 1140 Washington Blvd

15 [illegible] HAMPSON JONES, M. D. Registrar

JAN 18 1927

Per [illegible]

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 4, 1927, to Jan 16, 1927, that I last saw h[illegible] alive on Jan 15, 1927, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Bronchitis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary): Myocarditis (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Data Test

(Signed) J M Deberett M. D.

Jan 17 1927 (Address) 621 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Jan 20, 1927

20 UNDERTAKER: John J Feldo — ADDRESS: 1200 W Lombard

MAKE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 18027

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18027

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH City of BALTIMORE: (No.) Franklin Sq. Hosp. (Ward) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Merritt

(a) RESIDENCE NO. 1406 Ward St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colo

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Mary Merritt

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years: about 66 — Months: — Days: — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Globben Co — St. Helena

9 BIRTHPLACE (city or town):

(State or country): Unknown

PARENTS

10 NAME OF FATHER: Daniel Merritt

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Va

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Unknown

14 Informant: Rose Merritt

(Address): 1406 Ward St

JAN 18 1927 FILED J. HAMPSON JONES, M. D. Registrar

By R.R.

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 13th 1927

17 I HEREBY CERTIFY That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Broncho - Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Acute Alcoholism

(duration) yrs. mos. ds.

(Signed) Thos. D. Hopson M. D. (Coroner)

Jan 18th 1927 (Address) Curtis Bay Md

*State the Disease Causing Death, or in deaths from violent causes, state (1) Means and Nature of Injury, and whether Accidental, Suicidal, or Homicidal. (See rev[illegible] Accidental Causes.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Calvary Cem — Date of Burial: Jan 18 1927

20 UNDERTAKER: Mrs B A Elliott — ADDRESS: 1725 Ashland Ave

If DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 18028

E 18028

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 405 Fyson St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Demitia Smith

(a) RESIDENCE NO. 405 Fyson St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F. | Col | Married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)
1871

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 55 | | | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balt
(State or country)

PARENTS

10 NAME OF FATHER John Johnson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balt.

12 MAIDEN NAME OF MOTHER Hattie —

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto

14 Informant Amelia Mitchell
(Address) 405 Fyson St.

Filed JAN 18 1927 S. HAMPSON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927
1/14

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Mitral Regurgitation
Myocarditis
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) Harold Easter, M. D.
(Coroner)
, 1927 (Address) 3225 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Wether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19
Mt Auburn Cem Jan 17 1927

20 UNDERTAKER — ADDRESS
Harold Easter 946

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001

18029

## CERTIFICATE OF DEATH.

E 18029

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1744 Ashland Ave St., 7-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Wise

(a) RESIDENCE NO. 1744 Ashland St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | col | single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXXX

6 DATE OF BIRTH (month, day, and year) Jan 11/27

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | | | 4 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work XXXXXXXX

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto. Md

PARENTS

10 NAME OF FATHER Barton Spencer

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va.

12 MAIDEN NAME OF MOTHER Rosa Wise

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Rosa Wise

(Address) 1744 Ashland Ave

15 Filed JAN 18 1927 HIMSON JONES M. D. Registrar

By

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 Jan 15/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Prematurity-7 mons gestation

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) J. H. Allen M. D.

(Coroner)

1/18/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Cemt Date of Burial 1/18/27

20 UNDERTAKER Wm. P. A. Elliott ADDRESS 1727 Ashland Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18030

CERTIFICATE OF DEATH.

100-001

E 18030

1-PLACE OF DEATH Balto City Hospls. REGISTERED NO.

CITY OF BALTIMORE: (No. Balto, Md ST., 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Alvather

(a) RESIDENCE No. 2004 Eastern Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Wht | Unknown |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|
| 65 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Balto. City Hospls (Address) Balto Md

15 Filed JAN 18 1927 19 C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 1927 to Jan 14 1927

that I last saw him alive on Jan 14 1927

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Terminal Bronchopneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Psychosis with Deterioration

(duration) mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Harry F. Odonnell M. D.

1/15 1927 Address Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cemetery — DATE OF BURIAL 1/18 1927

20 UNDERTAKER J. A. Moran — ADDRESS 3000 E. Baltimore

IMPORTANT should be carefully supplied. Exact statement of OCCUPATION should be given so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18031

## CERTIFICATE OF DEATH

E 18031

REGISTERED NO. 100 005

1-PLACE OF DEATH

City of BALTIMORE: (No. 3707 Gough St. St. 20 Ward) 20-37

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ferdinand Brock

(a) RESIDENCE NO. 3707 Gough St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 26-1924

| 7 AGE | Years | Months | Days | IF LESS than 1 day ____ hrs. or ____ min.. |
|---|---|---|---|---|
| | 2 | 7. | 20 | 21 |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. pd

(b) General natura of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Frederick Brock.

11 BIRTHPLACE OF FATHER (City or town) Balto

(State or country) md.

12 MAIDEN NAME OF MOTHER Rosie Shank

13 BIRTHPLACE OF MOTHER (city or town) York

(State or country) Pa.

14 Informant Frederick Brock

(Address) 3707 Gough St.

15 Filed JAN 18 1927 C. HARRISON JONES, M. D. Registrar

Per ____

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 16 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1927, to Jan 16, 1927,

that I last saw him alive on Jan 16, 1927,

and that death occurred, on the date stated above, at 7.55 a. m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted unknown

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) Horace P Tatum, M. D.

1/16, 1927 (Address) 31 E. Highlandtown

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Salwarty Cem. Date of Burial Jan. 18th 1927

20 UNDERTAKER Lilly & Zeller ADDRESS 403 S Wolfe St

Spec.—1-12-23—M&T—500 Bks.

no number

E 18032

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

113 E 18032

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST. 262 WARD)

2-FULL NAME Lawrence Jr C Glynn

(a) RESIDENCE NO. 33 S Highland Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1yr yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 12-1926

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | | 4 | 5 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Lawrence C. Jr Glynn

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Eliz C. Jr Glynn Kestner

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant Records - JOHNS HOPKINS HOSPITAL
(Address)

15 Filed JAN 18 1927 C. HAMPSON JONES, M. D.
Per RKL Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17 1927

17 in Dispensary -

I HEREBY CERTIFY, That I attended deceased from Nov 9 1927 to Jan 17 1927

that I last saw h alive on Jan 10 1927

and that death occurred, on the date stated above, at 8 a — m.

The CAUSE OF DEATH* was as follows:

Acute gastrointestinal indigestion.

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Prematurity.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? No lesions at autopsy

(Signed) Thomas W Cornwall, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fairview Sacred Heart Cem. DATE OF BURIAL Jan. 18 1927

UNDERTAKER Lilly & Zeiler ADDRESS 403 S Wolfe St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 18033 HEALTH DEPARTMENT—CITY OF BALTIMORE E 18033

# CERTIFICATE OF DEATH.

1-PLACE OF DEATH Homewood Hosp. REGISTERED NO. 14-20101-00

CITY OF BALTIMORE: (No. 2724 N Charles St., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Tonya Johns

(a) RESIDENCE NO. 13 39 Fremont ST., WARD 26a

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fem

4 COLOR OR RACE Wh

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 13 1926

7 AGE

| Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|
| | 11 | 5 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Frank Johns

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Rose Evans

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Father

(Address) 1539 Greene St.

15 Filed JAN 20 1927, 19

C. HAMPSON JONES, M.D. Registrar

Per RKK

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 12, 1927. to Jan 18, 1927.

that I last saw h alive on Jan 18, 1927.

and that death occurred, on the date stated above, at 8.10 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia (a) Flu

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Tuberculosis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? 1338 Fremont

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Symptoms

(Signed) no Attending M. D.

1/18, 1927 (Address) 2724 N Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet DATE OF BURIAL 1/18 1927

20 UNDERTAKER Edwin Bowerson ADDRESS Calhoun Hasbrook

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 18034 (129) E 18034

PLACE OF DEATH

CITY OF BALTIMORE: (No. 14 S Pulaski ST. 70-69 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Leary

(a) RESIDENCE NO. 14 S Pulaski ST. WARD
(Usual place of abode)
Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Leary

6 DATE OF BIRTH (month, day, and year) May 27 1839

7 AGE: Years 87 | Months 8 | Days 20 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS
10 NAME OF FATHER Nicholas Ving
11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland
12 MAIDEN NAME OF MOTHER Mary English
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary Mooney
(Address) 14 S Pulaski

15 Filed JAN 18 1927 19 HARRY JONES, M. D. Registrar
By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 1927 to Jan 16 1927
that I last saw h alive on Jan 16 1927
and that death occurred, on the date stated above, at 4 P m.
The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Symptoms
(Signed) Walter Eliot M. D.
1927 (Address) 54 Tuxedo Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem
DATE OF BURIAL: 1/19 1927
UNDERTAKER: Emge & Farley
ADDRESS: Fulton & Lafayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18035

E 18035

## CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Childrens Hospital School ST. 10th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James J Keenan

(Residence in Baltimore: No. 929 Valley St. Baltimore, Md. St.; yrs., mos. da.)

### PERSONAL AND STATISTICAL PARTICULARS.

| 3-SEX. | 4-COLOR OR RACE. | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) |
|---|---|---|
| male | white | single |

6-DATE OF BIRTH. September 17, 1919
(Month) (Day) (Year)

7-AGE. 7 yrs. 4 mos. ds.

If LESS than 1 day, ....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER. James J. Keenan

11-BIRTHPLACE OF FATHER (State or Country). Ireland.

12-MAIDEN NAME OF MOTHER Agnes Byrne

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James J Keenan

(Address) 929 Valley St

15- C. HAMPSHIRE, M. D.

Filed JAN 18 1927 Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 17, 1927.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from December 1st 1926, to January 17 1927, that I saw him alive on January 17 1927, and that death occurred, on the date stated above, at 1 25 A m.

The CAUSE OF DEATH* was as follows:

(1) Lung Spontaneous pneumothorax (Left Side)
Pulmonary tuberculosis
following influenza
(Duration) one hour & thirty minutes. yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) Harold B. Baltimore M. D.

January 17, 1927. (Address) Childrens Hospital School Baltimore, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 1 mos. 16 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 929 Valley St Baltimore Md.

19-PLACE OF BURIAL OR REMOVAL. New Cathedral Cem DATE OF BURIAL. 1.19, 1927

20-UNDERTAKER George J Ruth ADDRESS 1735 Harford

Caution.—Before burial or removal of dead body, this certificate must be filed with the Registrar of the district in which death occurred. Please write in plain terms so that it may be properly examined. Read statement of OCCUPATION carefully. Every question important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 18036

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

167-001

E 18036

REGISTERED NO. _____

1-PLACE OF DEATH

City of BALTIMORE: (No. 4922 Harford Ave St. 27-44 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Olive M. Busch

(a) RESIDENCE NO. ~~4922~~ Harford Ave St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | white | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Busch.

6 DATE OF BIRTH (month, day, and year) Nov 30/1889

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 37 | 2 | 16 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 37

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town) _____ (State or country) England

PARENTS

10 NAME OF FATHER F. Armstrong

11 BIRTHPLACE OF FATHER (city or town) _____ (State or country) England

12 MAIDEN NAME OF MOTHER Harriet Thorne

13 BIRTHPLACE OF MOTHER (city or town) _____ (State or country) England

14 Informant John Busch (Address) 4922 Harford Ave

15 Filed _____, 19____ _____ Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Illuminating Gas Asphixiation

(Suicide)

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) _____ (duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. H. Ruth M. D.

(Coroner)

1/18/27 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery Date of Burial 1/19 1927

20 UNDERTAKER George O Ruth ADDRESS 1738 Harford Ave

JAN 21 1927 HAMPSON JONES, M. D.

Registrar

Cor.—12-9-25—A Co.—200 Bks. is ... OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION ... very important. See instructions on back of certificate.

Spec.—1-12-22—[illegible]—500 Bks.

Spec.—1-12-23—5&T—500 Bks.

E 18037 HEALTH DEPARTMENT—CITY OF BALTIMORE E 18037

# CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7-9 WARD)

2-FULL NAME William H. Palmer

(a) RESIDENCE NO. 8-7th St. ST., Bristol, Tenn. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 5 ds. How long in U. S., if of foreign birth? yrs. 2 mos. 5 ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| male | white | Divorced |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 15 1866

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 60 | 4 | 3 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pool Room Prop.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) Bristol Tenn.
(State or country)

PARENTS

10 NAME OF FATHER James Palmer

11 BIRTHPLACE OF FATHER (city or town) Bath Co.
(State or country)

12 MAIDEN NAME OF MOTHER Sallie Dunn

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 JAN 18 1927 C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 13, 1926, to Jan. 18, 1927, that I last saw h alive on Jan 18, 1927 and that death occurred, on the date stated above, at 5 40 P m.

The CAUSE OF DEATH* was as follows:

Melanotic Sarcoma.

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

Septicemia (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 11/15/26

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John Hopkins Hospital, M. D.

, 19 (Address) John Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| East Hill Cemetery Bristol Va. | Jan. 21 1927 |

20 UNDERTAKER ADDRESS

George L. Ruth 1735 Harford Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 18038

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18038

## CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2nd St & Chesapeake Ave ST. Brooklyn WARD 15

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William L Remmey

(a) RESIDENCE NO. 2nd St & Chesapeake Ave ST. Brooklyn WARD Balto

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Theresa Remmey

6 DATE OF BIRTH (month, day, and year): Oct 3rd 1857

7 AGE: 69 Years 3 Months 12 Days; If LESS than 1 day, hrs. or min.

10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Teamster

(b) General nature of industry, business, or establishment in which employed (or employer): City Street Cleaning

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Joseph Remmey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Philadelphia

12 MAIDEN NAME OF MOTHER: Mary Gladd

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Theresa Remmey (Address) Chesapeake Ave & 2nd St Brooklyn Md

15 Filed 1927 HAMPSON Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 15th 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan. 7th 1927 to Jan. 15th 1927.

that I last saw him alive on Jan. 14th 1927.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia following pleurisy

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Thos L Leibe M.D.

1/17, 1927 (Address) 1124-26 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem — DATE OF BURIAL: Jan 15th 1927

20 UNDERTAKER: Leo G. Cook — ADDRESS: 1725 N Patterson Park Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18039

E 18039

## CERTIFICATE OF DEATH.

90

REGISTERED NO. 7747

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 512 Arlington Av. (ST.) Govans (WARD)

2-FULL NAME Alfred Richard Chenowith

(a) RESIDENCE. No. 512 Arlington Av. ST., Govans WARD.
(Usual place of abode) all his life
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Cora J. M. Chenowith

6 DATE OF BIRTH (month, day, and year) Feb 9-1846

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 80 | 11 | 8 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Upholsterer

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Benj F. Chenowith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary Wood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Cora J. M. Chenowith
(Address) 512 Arlington Av.

15 Filed JAN 18 1927, 19 H. HAMPSON JONES, M. D., Registrar
By PCH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17. 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec. 27, 1926, to Jan. 16, 1927, that I last saw h[illegible] alive on Jan. 16, 1927, and that death occurred, on the date stated above, at 5:15 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) — yrs. — mos. 22 ds.

CONTRIBUTORY (Secondary) Mitral insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. D. Greenbaum, M. D.

1/17/1927 (Address) 3949 Greenmount Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Greenmount Cem | Jan 19 19 27 |
| 20 UNDERTAKER | ADDRESS |
| Chas E. Friend | [illegible] |

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CONDITION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18040 E 18040

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. 118-001

City of BALTIMORE: (No. 2828 Huntingdon St., 17-2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W Smith

(a) RESIDENCE NO. 2828 Huntingdon Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 8 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie Smith

6 DATE OF BIRTH (month, day, and year) Oct 13, 1870

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 56 | 3 | 3 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tool Dresser

(b) General nature of industry, business, or establishment in which employed (or employer) Otis

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country)

PARENTS

10 NAME OF FATHER Joseph Smith

11 BIRTHPLACE OF FATHER (City or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Susan Schultz

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Jennie Smith

(Address) 2828 Huntingdon Ave

Filed JAN 18 1927 C. HAMPSON JONES, M. D. Registrar

Per Neat

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16, 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 6, 1926 to Jan 16, 1927

that I last saw him alive on Jan 16, 1927

and that death occurred, on the date stated above, at 2.15 P. m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic tuberculosis, pulmonary

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Data of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Geo. W. Osborne, M. D.

, 19 (Address) 2413 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Park Date of Burial Jan 19 1927

20 UNDERTAKER Eichenwald & Son ADDRESS 341 Chestnut St

This should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—I-10-21—M&T—1500 Bks.

E 18041

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18041

## CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2754 Kinsey Ave ST. 20-14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gilbert Gillis Jr

(a) RESIDENCE NO. 2754 Kinsey Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. 0 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced (or) ~~WIFE~~ of HUSBAND of John Gillis

6 DATE OF BIRTH (month, day, and year) Dec 23, 1883

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 43 | 0 | 25 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Agent 189

(b) General nature of industry, business, or establishment in which employed (or employer) Shoe Industry

(c) Name of employer United Shoe Machinery Co

9 BIRTHPLACE (city or town) Balto Md

(State or country)

PARENTS

10 NAME OF FATHER Gilbert Gillis

11 BIRTHPLACE OF FATHER (city or town) Ireland

(State or country)

12 MAIDEN NAME OF MOTHER Jane Dodd

13 BIRTHPLACE OF MOTHER (city or town) England

(State or country)

14 Informant Mrs John Gillis

(Address) 2754 Kinsey Ave

15 JAN 18 1927 C. HAMPSON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 17 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1926, to Jany 17, 1927,

that I last saw him alive on Jany 16, 1927

and that death occurred, on the date stated above, at 6.15 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Intestines

(duration) yrs. 4 mos 17 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Mastrill M. D.

1/17, 1927 (Address) 1081 N Sutton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL 1/20/27

20 UNDERTAKER Harry A Wilson — ADDRESS 1531 W Lafayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

31 E 18042

E 18042

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 909 S. East Ave St. 26-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Milton P. Keiser

(a) RESIDENCE NO. 909 S. East Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 18. 1906

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min.. |
|---|---|---|---|---|
| | 20 | 11 | 28 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bookkeeper 008

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Maryland Casuality Co. Balto

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER Michael Keiser

11 BIRTHPLACE OF FATHER (City or town) Balto

(State or country) Md.

12 MAIDEN NAME OF MOTHER Lena Schmidt

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md.

14 Informant Michael Keiser

(Address) 909 S. East Ave

JAN 18 1927

15 C. HAMPSON JONES M. D.

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 13, 1927, to Jan 16, 1927,

that I last saw him alive on Jan 16, 1927,

and that death occurred, on the date stated above, at 11 55 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

Tuberculosis of Intestines. ?

(duration) 1Y yrs. mos. ds.

CONTRIBUTORY (Secondary) Laryngeal Tuberculosis.

(duration) yrs. 3 mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms -

(Signed) Louis F. Krumrein, M. D.

. 19 (Address) 722 N. Kenwood ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Oak Lawn Cemetery | Jan 19 1927 |
| 20 UNDERTAKER Henry Sander & Sons Inc | ADDRESS 1710 Fleet St. |

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state DISEASE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18043 101-081 E 18043

## CERTIFICATE OF DEATH

REGISTERED NO. 26-37

1-PLACE OF DEATH

City of BALTIMORE: (No. 10x S. Tenth St. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Hurget.

(a) RESIDENCE NO. 10x S. Tenth St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 8-1926

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min.. |
|---|---|---|---|---|
| | | 9 | 8 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Henry Hauck.

11 BIRTHPLACE OF FATHER (City or town) Balto.

(State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Hurget.

13 BIRTHPLACE OF MOTHER (city or town) Balto.

(State or country) Md.

14 Informant Annie E. Hoffman

(Address) 10x S. 10th St.

JAN 18 1927 C. HAMPSON JONES, M. D. Registrar

Por

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 16 - 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 15- 1927, to Jan 16 1927.

that I last saw h[illegible] alive on Jan 16 1927.

and that death occurred, on the date stated above, at 4.57 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Alexander Gutham, M. D.

1-18. 1927 (Address) 3524 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Mt. Carmel Cem. Jan. 18th 1927

20 UNDERTAKER — ADDRESS

Lilly and Jaile 403 S. Wolfe St.

DO NOT ABBREVIATE. PHYSICIANS should be extremely careful. Every item should be filled EXACTLY. Avoid abbreviations. Write plainly with pen and ink. Be sure that every item is properly answered. Avoid use of ditto marks. Be sure that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18044

E 18044

## CERTIFICATE OF DEATH

90

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 726 S. Third St. St. 26-37 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie Nolan.

(a) RESIDENCE NO. 726 S. Third St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S. if of foreign birth? 60 yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James Nolan.

6 DATE OF BIRTH (month, day, and year): April 17-1840

7 AGE — Years: 86 — Months: 9 — Days: 0 — IF LESS than 1 day ...hrs. or ...min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at home.

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Ireland.

PARENTS

10 NAME OF FATHER: Andrew Kinsella

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Ireland.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Ireland.

14 Informant: Dr. Lawrence G. Nolan.

(Address): 726 S. Third St.

Date: JAN 18 1927

C. HAMPSON JONES, M. D.

Registrar

By: R.C.H.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: Jan. 17-1927

17 I HEREBY CERTIFY, That I attended deceased from 12/16, 1926, to 1/17, 1927.

that I last saw h-- alive on 1/16, 1927.

and that death occurred, on the date stated above, at 2.45 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis & Arteriosclerosis

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Hydro Static Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo. Garrett M. D.

1/18, 1927 (Address) 433-5-34

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral. — Date of Burial: Jan. 19 1927.

20 UNDERTAKER: Lilly & Zahn — ADDRESS: 403 S. Wolfe St.

tion should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Bks.

E 18045

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18045

## CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 531 N. Milton Ave. ST.: 7-10 WARD)

2-FULL NAME Wilhelmina Treff.

(a) RESIDENCE. No. 531 N. Milton Ave, ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. 5 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louis Treff

6 DATE OF BIRTH (month, day, and year): July 23, 1854

7 AGE

| Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|
| 72 | 5 | 18 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: George C. Zuen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Catherine Rabenau

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Louis Treff (Address) 587 N. Milton Ave

15 FILED 1 8 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 17 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 25, 1926, to Jan 17, 1927, that I last saw her alive on Jan 17, 1927, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Arterial Hypertension
Myocardial Insufficiency
(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema
(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. J. Geyer M. D.

. 19 (Address) 156 N. Milton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. DATE OF BURIAL: Jan 20th 1927

20 UNDERTAKER: E. Schloman & Son ADDRESS: 1037 Hanover St.

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 18046

# HEALTH DEPARTMENT—CITY OF BALTIMORE

90

E 18046

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 238 S. Calvert St St., 9-47 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ed. A. Gorsuch

(a) RESIDENCE NO. 1130 E. 36th St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? Life yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | white | widower |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes Gorsuch

6 DATE OF BIRTH (month, day, and year) 8/5/1869

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....brs. or.....min. |
|---|---|---|---|---|
| | 57 | 5 | 12 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Printer

(b) General nature of industry, business, or establishment in which employed (or employer) 069

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country)

PARENTS

10 NAME OF FATHER E. Gorsuch

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country)

12 MAIDEN NAME OF MOTHER Louise C. Gru

13 BIRTHPLACE OF MOTHER (city or town) Balt

(State or country)

14 Informant Louis Gorsuch

(Address) 1130 E. 36

15 1-8-1927 C. HAMPSON JONES, M. D.

Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valv disease heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner)

Jan 17, 1927 (Address) 1637 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery Date of Burial 1/20 1927

20 UNDERTAKER George & Ruth ADDRESS 1735 Harford Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 18047

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18047

## CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 23 n Linwood ave ST., 6-11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME anna Chelewicz

(a) RESIDENCE NO. 23 n Linwood ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4½ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | W | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 6 1893

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min |
|---|---|---|---|---|
| | 33 | 10 | 11 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Ostend Chelewicz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Stanislawa Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mrs Stanislawa Chelewicz

(Address) 23 n Linwood ave

15 1927 C. HAMPSON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17 1927

17 I HEREBY CERTIFY, That I attended deceased from 5/10, 1924, to 1-17, 1927, that I last saw h[illegible] alive on 1/15, 1927, and that death occurred, on the date stated above, at 5.15 A m

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) [illegible] yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Adam Drake, M. D.

1927 (Address) 1125 Eutaw pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Holy Rosary cem | Jan 18 1927 |
| 20 UNDERTAKER | ADDRESS |
| John M Weber | 1803 Bank st |

TION is very important See instructions on back of certificates.

Spec.—1-12/23—M&S—500 Bks.

1927 4567

E 18048

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18048

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No.) ..... ST., 7-9 (WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cecil Helicau

(a) RESIDENCE NO. Inwood W. Va. ST., ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 26 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. Va.

PARENTS

10 NAME OF FATHER Wm Helicau

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 JAN 18 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 14 1926, to Jan 18 1927, that I last saw h[illegible] alive on Jan. 18 1927 and that death occurred, on the date stated above, at 11 40 A. M.

The CAUSE OF DEATH* was as follows:

Diffuse Sarcomatosis (Malignant Tumor)

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 11/14/27

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) George G. Finney, M. D.

Jan 18 1927 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Martinsburg W. Va. | Jan 19 1927 |
| 20 UNDERTAKER George J. Smith | ADDRESS 1532 Hollins |

TION is very important See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 18049

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18049

## CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2108 Gough ST. 1-3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jeannette Dziwulski

(a) RESIDENCE. NO. 2108 Gough N ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 16-1926

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 1 | 5 | 3 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Jan Dziwulski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Zerenda

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Jan Dziwulski 2108 Gough St

15 JAN 8 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 18, 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 16, 1927, to Jan. 18, 1927, that I last saw her alive on Jan. 18, 1927, and that death occurred, on the date stated above, at 12.45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchs - Pneumonia (primary)

(duration) yrs. - mos. 3 ds.

CONTRIBUTORY (Secondary) Convulsions & heart dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at residence

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Emil Zeigler, M. D.

1/8, 1927 (Address) 1900 E. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary

DATE OF BURIAL: Jan 20 1927

20 UNDERTAKER: John M. Weber

ADDRESS: 1803 Bank St

TION is very important. See instructions on back of certificates.

Spec– 12-23-21—E.B.R.S.—400 Bks.

E 18050

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18050

## CERTIFICATE OF DEATH.

160

1-PLACE OF DEATH

City of BALTIMORE: (No. 2887 N Balto St. 70-69 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Smith

(a) Residence No. 2887 N Balto St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) infant

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Jan 17-27

7-AGE

If LESS than 1 day

yrs. mos. ds. hrs. or 30 min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS

10-NAME OF FATHER, Charles Smith

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Penna

12-MAIDEN NAME OF MOTHER, Estelle Zeune

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), md

14- (Informant) Charles Smith Jr

(Address) 2887 W Balto St

15- JAN 18 1927 C. HANPSON JONES, M. D. Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 17-27

17- I HEREBY CERTIFY, That I attended deceased from Jan 17 in 27 to 19

that I last saw h alive on Jan 17 in 27

and that death occurred, on the date stated above, at o.

The CAUSE OF DEATH* was as follows:

Premature Second Child of Term Pregnancy at Birth

Lived 30 minutes

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward A Morgan M D

, 19 (Address) 1325 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION, OR REMOVAL. Mt Olivet Cem. DATE OF BURIAL. 1/19/27 19

20-UNDERTAKER. Harry A Walsh ADDRESS N 3110 Loudon

instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

E 18051

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18051

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH — CITY OF BALTIMORE: (No.) In taxicab en route from Balto. & Charles Sts. to Carroll Road & Wirt Ave. (St.) 47-55 89 (Ward) — REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME: Sydney Juhn

(a) RESIDENCE NO. (Usual place of abode): Carroll Road & Wirt Ave. ST., WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred: Lifetime. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Beatrice Fisher Juhn.

6 DATE OF BIRTH (month, day, and year): July 28th. 1881.

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 45 | 5 | 22 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Manufacturer of
(b) General nature of industry, business, or establishment in which employed (or employer): Underwear.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland.

PARENTS

10 NAME OF FATHER: Max Juhn.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Lina Stiefel,

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland.

14 Informant (Address): Mr. Morton Fisher, Balto. Md.

15 Filed 8 1927 — C. HAMPSON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jany. 17th. 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy (or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Angina Pectoris

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) [signature] M. D. (Coroner)

1/18, 1927 (Address) 363 Roland Av

*Give the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oheb Shalom Cemetery. DATE OF BURIAL: 1/19/ 1927

20 UNDERTAKER: Baird Sondheim ADDRESS: 1320 Eutaw Pl

Spec.—1-12-23—M&T—500 Bks.

E 18052

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18052

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) U.S. Marine Hospital (St.) 12-51 (WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dan Carter

(a) RESIDENCE NO. 10 Lincoln St - Newton WARD N.C.
(If usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) birthday unknown 1909

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 18 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Seaman

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: Moore & Pratt

9 BIRTHPLACE (city or town) (State or country): North Carolina

PARENTS

10 NAME OF FATHER: Daniel Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country): North Carolina

12 MAIDEN NAME OF MOTHER: Minnie (?)

13 BIRTHPLACE OF MOTHER (city or town) (State or country): North Carolina

14 Informant (Address): Hospital Records

15 FILED 1 8 1927 19

C. HAMPSON JONES, M. D.
Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1927, to Jan 16, 1927, that I last saw him alive on Jan 16, 1927, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos 1 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings & laboratory tests

(Signed) W. O. Newton M. D.
Asst Surgeon, U. S. Public Health Service

1-16, 1927 (Address) U S Marine Hospital, Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem

DATE OF BURIAL: Jan 19 1927

20 UNDERTAKER: E. LeRoy Stiffler

ADDRESS: 1235 North Ave

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# E 18053 HEALTH DEPARTMENT—CITY OF BALTIMORE 31 E 18053

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH U.S. Marine Hospital #1 REGISTERED NO. 22-31

CITY OF BALTIMORE: (No. Balt Md. ST. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry McCoy.

(a) RESIDENCE NO. 827 Hanover St. ST. ..... WARD .....
(Usual place of abode) Balt Md (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. — mos. — ds. How long in U. S., If of foreign birth? — yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 10, 1843

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 33 | 7 | 8 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman 086

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman

(c) Name of employer S/S Alma Arundel

9 BIRTHPLACE (city or town) (State or country) S.C.

PARENTS

10 NAME OF FATHER Henry McCoy.

11 BIRTHPLACE OF FATHER (city or town) (State or country) S.C.

12 MAIDEN NAME OF MOTHER M. Duffy.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S.C.

14 Informant Self
(Address)

8 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 27, 1926, to January 18, 1927; that I last saw h— alive on January 18, 1927, and that death occurred, on the date stated above, at 1:50 m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Lobar.

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Tuberculosis, pulmonary. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Un known.

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Physical findings + laboratory test.

(Signed) H. Hagerman, M. D.

, 19 (Address) U S Marine Hospital #1. Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem DATE OF BURIAL Jan 19 1927

20 UNDERTAKER E L Roy Stiffler ADDRESS 125 North Ave

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18054

## CERTIFICATE OF DEATH.

E 18054

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1125 N. Gay ST. 8-13 WARD)

2-FULL NAME John May Mitchell

(a) RESIDENCE No. 1125 N Gay ST., ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. / mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widower |

5a If married, widowed, or divorced (or) WIFE of Mollie P. Mitchell

6 DATE OF BIRTH (month, day, and year) May 19, 1861

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 65 | 9 | 30 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Novak & Moran

9 BIRTHPLACE (city or town) Harford County (State or country) Md

PARENTS

10 NAME OF FATHER Horton Mitchell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Faithful E. Flaherty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant William Clatterbuck

(Address) 1125 N. Gay St.

Filed JAN 19 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec. 10, 1926 to Jan 18, 1927.

that I last saw h alive on Jan 17, 1927

and that death occurred, on the date stated above, at 12 50 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease.

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Vincent V. Cooke M. D.

, 19 (Address) 745 N. Patterson Pk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Aberdeen, Md.

DATE OF BURIAL Jan 21 1927

20 UNDERTAKER Zirkler & Zirkler

ADDRESS 1739 E. Eager St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18055

## CERTIFICATE OF DEATH.

188-001

E 18055

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Clinton St. 1284-1 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas. E Dranbauer.

(a) RESIDENCE NO. 2823 Hudson St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 17-1907

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 19 | 10 | 29 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brakeman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer P. R. R.

9 BIRTHPLACE (city or town)

(State or country) Balto., Md

PARENTS

10 NAME OF FATHER Chas. E. Dranbauer

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Eliz. Williams

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) A. A. Co.

14 Informant Elizabeth Dranbauer

(Address) 2823 Hudson St.

JAN 19 1927 Filed 19 C. HAMPSON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

R.R. Injuries Multiple Fractures Instant Shock.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Instant

(Duration) yrs. mos. ds.

Jan 17 1927 (Signed) J. C. Hiden M. D.

(Corner)

(Address) 143 Mt Bray

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakland Cem. Date of Burial Jan 19 1927

20 UNDERTAKER Zickler & Zickler ADDRESS 1739 E. Eager St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18056

## CERTIFICATE OF DEATH.

74-001

E 18056 REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1000 Hollins St., 18-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dora Theisen

(a) RESIDENCE NO. 1000 Hollins St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown 1860

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| about | 66 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) — 037

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant John R. Quent

(Address) 1609 Coleraine Road Catonsville, Md.

15 Filed JAN 19 1927, 19... C. HAMPSON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) at once yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Thos B. Horton M. D. (Coroner)

Jan 17th 1927 (Address) Curtis Bay, Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the state.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem Date of Burial Jan 19 1927

UNDERTAKER Wm F Logue & Son ADDRESS 90 Hollins St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18057

## CERTIFICATE OF DEATH.

REGISTERED No. E 18057

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 723 School St. 15-23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charlotte Greene

(Residence in Baltimore: No. 723 School St.; 30 yrs. mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, May 11, 1852 (Month) (Day) (Year)

7-AGE 74 yrs. 8 mos. 5 ds. If LESS than 1 day, ....hrs. or ....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Calvert Co. Md

PARENTS.

10-NAME OF FATHER. Holliday Blake

11-BIRTHPLACE OF FATHER (State or Country). Calvert Co. Md

12-MAIDEN NAME OF MOTHER Maria Johnson

13-BIRTHPLACE OF MOTHER (State or Country). Calvert Co. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Green

(Address) 723 School St.

15- Filed Jan 19, 1927 C. HAMPSON JONES, M. D. Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 1 (Month) 16 (Day) 1927 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 12 1927, to Jan 16 1927, that I saw h-er alive on 1 12 16 1927, and that death occurred, on the date stated above, at 3.30 P.M.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

4 da

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxemia

(Duration) yrs. mos. ds.

(Signed) C. Hampson Jones M. D.

1 17 1927 (Address) 618 Cathedral

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn DATE OF BURIAL, Jan 19, 1927

20-UNDERTAKER. Virginia A. Brooks ADDRESS 1463 N. Carey

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 18058

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18058

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2112 N. Calvert (ST.) 12-50 (WARD) REGISTERED NO. 45

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane Smart

(a) RESIDENCE NO. 2112 N. Calvert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frederick G. Smart

6 DATE OF BIRTH (month, day, and year): Sept 19-1858

7 AGE — Years: 68 Months: 3 Days: 28 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ontario

PARENTS

10 NAME OF FATHER: George Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Scotland

12 MAIDEN NAME OF MOTHER: Margaret Smart

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Scotland

14 Informant: Dr. Alex B. Smart

(Address) 2112 N. Calvert St

15 Filed JAN 19 1927 C. HAMPSON JONES, M.D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 17 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1927, to Jan. 15, 1927, that I last saw h[er] alive on Jan. 15, 1927, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Colon

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary): Hypertrophic-Arteriosclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar P. Sandrock, M. D.

(Address) 154 W. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park DATE OF BURIAL: Jan 19 1927

20 UNDERTAKER: John O. Mitchell ADDRESS: 1918 Eutaw Pl

TION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18059

## CERTIFICATE OF DEATH

101-001

E 18059

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 2545 Francis St. 13-59 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Rose Ludwig

(a) RESIDENCE NO. 2545 Francis St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John B. Ludwig

6 DATE OF BIRTH (month, day, and year): Jany 4 1868

7 AGE — Years: 59 — Months: 0 — Days: 12 — IF LESS than 1 day ____ hrs. or ____ min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Bolton

(State or country): Md

PARENTS

10 NAME OF FATHER: Jno V. Lotz

11 BIRTHPLACE OF FATHER (City or town): Germany

(State or country)

12 MAIDEN NAME OF MOTHER: Elizabeth Schmidt

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Germany

14 Informant: John B. Ludwig

(Address): 2545 Francis St

15 Filed JAN 19 1927 19 C. HAMPSON JONES, M. D. Registrar

By [illegible]

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 16 19 27

17 I HEREBY CERTIFY, That I attended deceased from Jany 9, 19 27 to Jany 16, 19 27

that I last saw h[illegible] alive on Jany 16 19 27

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Right Lobar pneumonia

(duration) yrs. mos. 8 da.

CONTRIBUTORY (Secondary): Acute cardiac dil.

(duration) yrs. mos. 1 da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical signs

(Signed) George Abner Bowden, M. D.

1/19, 19 27 (Address) 1517 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

Date of Burial: Jan 19 19 27

20 UNDERTAKER: W. J. Rockwell Sons

ADDRESS: Nor Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

Lena Wolf

# E 18060

HEALTH DEPARTMENT—CITY OF BALTIMORE

45

# E 18060

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 5211 Elmer av. St. 27-48 Ward)

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Lena Wolf.

(a) RESIDENCE NO. 5211 Elmer av St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced. (write the word): married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thos. Wolf.

6 DATE OF BIRTH (month, day, and year): Jan. 3 1865

7 AGE: Years 62 | Months 11 | Days 16 17 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Germany.

(State or country)

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant (Husband)

(Address) 5211 Elmer av

15 Filed ..... 19 HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 17 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept. 15, 1926 to Jan. 17, 1927, that I last saw h.er alive on Jan. 17, 1927 and that death occurred, on the date stated above, at 7P m.

The CAUSE OF DEATH* was as follows:

Cancer - abdominal

(duration) yrs. 14 mos. ds.

CONTRIBUTORY (Secondary) Valvular heart disease ?

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X Ray

(Signed) Phil. Graham, M. D.

, 19 (Address) 820 W. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem. Date of Burial Jan. 20 1927

20 UNDERTAKER: Wm. J. Tucker Sons ADDRESS North & Pa

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

# E 18061 HEALTH DEPARTMENT—CITY OF BALTIMORE E 18061

## CERTIFICATE OF DEATH.

24-091

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1314 Fremont Ave ST. 15-23 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Jefferis

(a) RESIDENCE NO. 1314 Fremont Ave ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Colored | widow |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1887

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 40 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Ella Jefferis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Jos. Stewart (Address) 1314 Fremont Ave

15 Filed ..... 19 C. HAMPSON JONES, M. D. Registrar

19 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 16, 1927, to Jan 18, 1927

that I last saw her alive on Jan 18, 1927.

and that death occurred, on the date stated above, at 5.30 A, m.

The CAUSE OF DEATH* was as follows:

Paralysis Cerebral Hemorrhage

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) (a) Phthisis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation & Symptoms

(Signed) C. H. Jones, M. D.

Jan 18 1927 (Address) 1115 Druid Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rockville Md — DATE OF BURIAL Jan 19 1927

20 UNDERTAKER Hamil Easton — ADDRESS Balto

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Lowry

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18062

## CERTIFICATE OF DEATH.

74-001

E 18062

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 612 W Biddle ST. 17-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Basil Lowry

(a) RESIDENCE NO. 612 W Biddle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fannie Lowry

6 DATE OF BIRTH (month, day, and year) Sept-10-1856

7 AGE — Years: 70 — Months: 4 — Days: 5 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Barber

(b) General nature of industry, business, or establishment in which employed (or employer): Barber

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Carroll Co Md

PARENTS

10 NAME OF FATHER: Henry Lowry

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Lita Gelbs

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Fannie Lowry (Address) 612 W Biddle

15 Filed JAN 19 1927 19 C. HARRISON JONES, M.D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 15 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 10, 1927, to Jan 15 1927, that I last saw him alive on Jan 15 1927, and that death occurred, on the date stated above, at 12:21 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (duration) 0 yrs. 0 mos 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) 5 yrs. 4 mos. 5 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Clinical symptoms

(Signed) R B Kemp on M. D.

Jan 19 1927 (Address) 617 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem

DATE OF BURIAL: Jan 19 27

20 UNDERTAKER: Samuel Hemsley

ADDRESS: 578 N Eutaw

TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18063

## CERTIFICATE OF DEATH.

90 ✓ E 18063

1-PLACE OF DEATH

REGISTERED NO. _____

City of BALTIMORE: (No. 1809 Division St. 14-20 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME William Hiram McCann

(a) RESIDENCE NO. 1809 Division St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | Married |

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary C McCann

6 DATE OF BIRTH (month, day, and year) Mar 15 1843

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 83 | 9/10 | 2 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Post Office

(c) Name of employer

9 BIRTHPLACE (city or town) Emmitsburg

(State or country) Md

PARENTS

10 NAME OF FATHER Andrew McCann

11 BIRTHPLACE OF FATHER (city or town) Emmitsburg

(State or country) Md

12 MAIDEN NAME OF MOTHER Caroline Fleming

13 BIRTHPLACE OF MOTHER (city or town) Emmitsburg

(State or country) Md

14 Informant Mary C McCann

(Address) 1809 Division St

Filed JAN 19 1927 S. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17 1927

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1926, to Jan 17, 1927, that I last saw him alive on Jan 14, 1927, and that death occurred, on the date stated above, at 12:20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm Hiram McCann, M. D.

1/18, 1927 (Address) 1928 Fenwick Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bd. Auburn Cem. Date of Burial: 1/20 1927

20 UNDERTAKER: Samuel Hemsley ADDRESS: 578 N Dudle

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

19899 I

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 13064

## CERTIFICATE OF DEATH.

X 101-001

E 13064

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST. 8-16 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cadmus Ingram

(a) RESIDENCE NO. 1832 N. Duncan ST. ..... WARD 9a
(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | Baby |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 10-16-26

| 7 AGE Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|
| | 2 3 | 1 | |

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ..... (State or country) Va -

PARENTS

10 NAME OF FATHER Harry Ingram

11 BIRTHPLACE OF FATHER (city or town) Va - (State or country)

12 MAIDEN NAME OF MOTHER Mary Fisher

13 BIRTHPLACE OF MOTHER (city or town) ..... Balto (State or country)

14 Informant Rosa da - (Address) JOHNS HOPKINS HOSPITAL

15 Filed JAN 19 1927 C. HAMILTON JONES, M.D. By K.M. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 6 1927 to Jan 17 1927

that I last saw h~~im~~ive on Jan 17 1927

and that death occurred, on the date stated above, at 2 45 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X Ray

(Signed) Thomas W. Cornell, M.D.

(Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery — DATE OF BURIAL Jan 19 1927

UNDERTAKER Geo E. Miller & Son — ADDRESS 2334 Diffen Av.

TION is very important See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 18065

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

66 E 18065

REGISTERED NO.

22-31

1-PLACE OF DEATH

City of BALTIMORE: (No. 113 Hammerbacher Coutt St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jerome Johnson.(C)

(a) RESIDENCE NO. 829 Plum Alley. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 2 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, HUSBAND of: Frances Johnson.(C)

6 DATE OF BIRTH (month, day, and year): November 7, 1881

7 AGE — Years: 45 — Months: 2 — Days: 9 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Do not know.

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Do not know.

12 MAIDEN NAME OF MOTHER: Do not know.

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Do not know.

14 Informant: Frances Johnson.(C) wife.

(Address): 829 Plum Alley.

15 Filed JAN 19 1927 Registrar

Per

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): January 18, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Fennaeck M. D.

1/17 1927 (Address) 1017 E. Cortes St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Zion Ct — Date of Burial: Jan 19 1927

20 UNDERTAKER: S. L. Brown & Son — ADDRESS: 108 W. Fayette St

Be sure that all questions are answered, so far as may be proper, and that the certificate is signed. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

101-001

E 18066

E 18066

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Providence Hosp. Street) 23-31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Greene

(a) RESIDENCE NO. 1015 South Howard st. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colord | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)
Feb. ? 1850

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min.. |
|---|---|---|---|---|
| | 76 | 11 | — | |

77.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butler

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer ?

9 BIRTHPLACE (city or town) ?

(State or country)

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (City or town) ?

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?

(State or country)

14 Informant Elmina Green

(Address) 1015 S Howard st

JAN 19 1927 Registered Harrison Jones

Per [signature] Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

1-18-27

17 I HEREBY CERTIFY, That I attended deceased from 1-18-27 to 1-18-27 19

that I last saw him alive on night 1-17-27 19

and that death occurred, on the date stated above, at 3 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) old age & Exposure and myocarditis.

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical & Clinical

(Signed) E. C. Melton, M. D.

19 (Address) 2017 Penna. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Ct

Date of Burial Jan 19 1927

20 UNDERTAKER A. L. Brown & Son

ADDRESS 108 N. Monty

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18067

## CERTIFICATE OF DEATH

129

E 18067

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1345 Highland St. (or Ward) Ward 24)

2-FULL NAME Charles Gaetano Crosby

(a) RESIDENCE NO. 1345 Highland Ave Ward 24

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 11 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced: HUSBAND of (or) WIFE of: Matilda L Crosby

6 DATE OF BIRTH (month, day, and year): Feb 1852

7 AGE: Years 74 Months 11 Days

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Watchman

(b) General natore of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country)

PARENTS

10 NAME OF FATHER: Geo. Crosby

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Balto

12 MAIDEN NAME OF MOTHER: Charlotte —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Baltimore

14 Informant: Mrs Matilda Crosby

(Address): 1345 Highland Ave

15 DATE RECEIVED: JAN 19 1927

16 C. HAMPSON JONES, M. D., Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/16 1927

17 I HEREBY CERTIFY, That I attended deceased from 11/15, 1927, to 1/16, 1927,

that I last saw h[illegible] alive on 1/15, 1927

and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Asc Pulm Oedema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Senility Emphysema

Chr. Ent. Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation preeede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. L. Snader, M. D.

1/16 1927 (Address) 3323 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery

Date of Burial: Jan 19 1927

20 UNDERTAKER: Lilly-Zeiler

ADDRESS: 4033 Woodland

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18068

## CERTIFICATE OF DEATH.

90 E 18068

REGISTERED NO.

27-53

1-PLACE OF DEATH

City of BALTIMORE: (No. 919 Falls Road Terrace St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertie Whiton Boller

(a) RESIDENCE NO 919 Falls Road Terrace St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced ~~HUSBAND~~ or WIFE of: Late Peter S. Boller

6 DATE OF BIRTH (month, day, and year): June 28/63

7 AGE: Years 63 | Months 6 | Days 20 30 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town): Newark

(State or country): N. J.

PARENTS

10 NAME OF FATHER: Albert G. Whiton

11 BIRTHPLACE OF FATHER (city or town):

(State or country): N. J.

12 MAIDEN NAME OF MOTHER: Laura V. Jones

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): N. J.

14 Informant: Mrs Alberta R. Darley

(Address) 919 Fall Rd. Ter.

15 Filed JAN 19 1927, 19

C. HARRISON JONES, M.D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 1/18/27

17 I HEREBY CERTIFY, That I attended deceased from Nov. 26, 1926, to Jan. 18, 1927.

that I last saw her alive on Jan. 17, 1927.

and that death occurred, on the date stated above, at 6 m.

The CAUSE OF DEATH* was as follows:

Cancer, arteriosclerosis

Chronic Interstitial Nephritis

Chronic Endocarditis.

Pleurisy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Myocardial Insufficiency.

about 6

(duration) yrs. mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Carroll Lovejoy, M. D.

JAN 18 1927 (Address) 4 E Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Mt Jackson Va.

Date of Burial 1/20 19 27

20 UNDERTAKER: Philip Herring

ADDRESS 2016 Orleans St.

Very important. See instructions on back of certificates.

E 18069

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

18-002

E 18069

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St. 26-37 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry F. Taylor

(Residence in Baltimore: No. 6207 Eastern ave St.; yrs. 33 mos. 5 ds. 22)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: July 24th (Month) (Day) 1893 (Year)

7-AGE: 33 yrs. 5 mos. 22 ds.

If LESS than 1 day, ....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House Painter
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto

PARENTS.

10-NAME OF FATHER: Wm Taylor

11-BIRTHPLACE OF FATHER, (State or Country): Md

12-MAIDEN NAME OF MOTHER: Mary Ewalt

13-BIRTHPLACE OF MOTHER, (State or Country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lillian B. Taylor

(Address) 6207 Eastern ave

15- JAN 19 1927 G. HAMPTON JONES, M. D. Registrar.

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 16th (Day) 1927 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lt. Car Hod.

Fracture of Skull.

(Duration) ... yrs. ... mos. 4hrs. ds.

CONTRIBUTORY (Secondary) Shock.

(Duration) ... yrs. ... mos. 1 ds.

(Signed) G. D. Dalton M. D.

(Coroner)

Jan 18 1927 (Address) 143 W. Gray

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Oak Lawn

DATE OF BURIAL: 1/19 1927

20-UNDERTAKER: Philip Henry

ADDRESS 2016 Orleans st

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18070

## CERTIFICATE OF DEATH.

32 E 18070

1-PLACE OF DEATH Union Memorial Hospital REGISTERED NO. 27-48

CITY OF BALTIMORE: (No. 33d & Calvert Sts ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth E. Lynch

(a) RESIDENCE NO. 5701 York Rd ST. WARD Roma

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 1 mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) February 1926

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 0 | 11 | ? | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Ralph Lynch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Katherine Gans

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records (Address)

Filed JAN 19 1927 . 19 C. HAMPSON JONES M.D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 18 1927

17

I HEREBY CERTIFY, That I attended deceased from January 12, 1927, to January 18, 1927, that I last saw her alive on January 18, 1927, and that death occurred, on the date stated above, at 8 30 P m.

The CAUSE OF DEATH* was as follows:

Meningitis, tubercular

(duration) yrs. mos 23 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Lab. & clinical methods

(Signed) Frank R Smith, Jr. M. D.

. 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Cathedral Cemetery | 1/19, 1927 |
| UNDERTAKER Henry U. Mears' Son | ADDRESS 805 N. Calvert |

TION IS very important. See instructions on back of certificates.

Spec.—1-12-26—M&T—500 Bks.

1918

# HEALTH DEPARTMENT—CITY OF BALTIMORE

1918 E 18071

## CERTIFICATE OF DEATH.

51

E 18071

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (NO. ..... ST. 1-3 WARD)

2-FULL NAME Evelyn Butler

(a) RESIDENCE NO. 1085 Duncan ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| female | col | |

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1-11-1920

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 7 | | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... ood

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) ..... (State or country) Md.

PARENTS

10 NAME OF FATHER Charles Butler

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Md.

12 MAIDEN NAME OF MOTHER Florence Johnson

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Md.

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 FILED JAN 19 1927 H. HAMPSON JONES, M. D. Registrar
Per ....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 17 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 12, 1927, to Jan. 17, 1927, that I last saw h alive on Jan 17, 1927 and that death occurred, on the date stated above, at 5-30 a. m.

The CAUSE OF DEATH* was as follows:

rheumatic with acute pericarditis & heart failure

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) rheumatic fever;

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? NO Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Henry W Cornwall, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Laurel Cemetery | Jan 20 1927 |

20 UNDERTAKER Thos & Chas E. Bailey ADDRESS 421 Jefferson St

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18072

## CERTIFICATE OF DEATH.

E 18072

1-PLACE OF DEATH Mercy Hospital

City of BALTIMORE: (No. 25-65-57 St. Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emily Smith

(a) RESIDENCE NO. Timber Mill Road St. Hillsdale Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 8, 1851

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 75 76 | 7 | 10 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER Elihu Smith

11 BIRTHPLACE OF FATHER (city or town) Baltimore Co Md

(State or country)

12 MAIDEN NAME OF MOTHER Rachel Smith

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Co Md

(State or country)

14 Informant Charles F. Smith

(Address) 1806 Braddish Ave

JAN 19 1927 19 C. HAMPSON JONES, M. D. Registrar

Per R.F.C.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18 19 27

17

I HEREBY CERTIFY, That I attended deceased from July 10, 1927, to Jan 18, 1927

that I last saw h[illegible] alive on Jan 18, 1927

and that death occurred, on the date stated above, at 7 A.M. P.M.

The CAUSE OF DEATH* was as follows:

Terminal Pneumonia

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Diabetes + nephritis Chronic

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. Gundlach M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemetery Date of Burial 1/21 1927

20 UNDERTAKER: George J. Smith ADDRESS 1532 Hollins

very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

Dr Campbell, Honorary Health.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002

## CERTIFICATE OF DEATH

E 18073

REGISTERED NO. E 18073

1-PLACE OF DEATH

City of BALTIMORE: (No. 132 N. Front Ave St. 23-37 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mansfield A. Watson

(a) RESIDENCE NO. 132 N. Front Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Matilda A Watson

6 DATE OF BIRTH (month, day, and year) Aug 14, 1843

| 7 AGE | Years | Months | Days | IF LESS than 1 day ____ hrs. or ____ min.. |
|---|---|---|---|---|
| | 83 | 5 | 12 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in whirh employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) W. Va

PARENTS

10 NAME OF FATHER Hiram Watson

11 BIRTHPLACE OF FATHER (City or town)

(State or country) W. Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) W. Va

14 Informant Victoria A Stuckrath

(Address) 132 N. Front Ave

Filed JAN 19 1927 C. HAMPSON JONES, M. D.

Per RAL Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1926 to Jan 15, 1927

that I last saw h alive on Jan 15, 1927

and that death occurred, on the date stated above, at 11:50 P. m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis

(duration) Indefinite yrs. mos. ds.

CONTRIBUTORY (Secondary) Cystanchoma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. P. Campbell M. D.

18, 1927 (Address) 166 E Hamburg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — Date of Burial Jan 19 1927

20 UNDERTAKER W. H. Cox — ADDRESS Fayette

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 18074

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18074

## CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 37 Royal Oak Ave St. 28-b 24 Ward)

2-FULL NAME Frank H. Moore

(a) RESIDENCE NO. 37 Royal Oak Ave St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 4 mos. 2 dys. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male. | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amelia Moore

6 DATE OF BIRTH (month, day, and year) September 15-1870

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 56 | 4 | 2 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Advertising Agent

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer Shafer Co

9 BIRTHPLACE (city or town) _____ Jan 17, 1927

(State or country) Maryland.

PARENTS

10 NAME OF FATHER Samuel J. Moore

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Maryland.

14 Informant Amelia Moore

(Address) 37 Royal Oak ave

15 Filed _____ 19__ C. HAMPTON JONES, M. D.

JAN 19 1927 Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to h... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage,

(duration) ____ yrs. ____ mos. 1 ds.

CONTRIBUTORY (Secondary) no. Lues

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. T. Heuisler, M. D. (Coroner)

Jan 17, 1927 (Address) 1807 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem Date of Burial 1-20 1927

20 UNDERTAKER E & B Karle ADDRESS 115 E Mead St

very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

111-001

E 18075

E 18075

## CERTIFICATE OF DEATH

REGISTERED NO. 2269

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Hoke

(a) RESIDENCE NO. 2658 Frederick ave St. 20th Ward

(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. 9 mos. 28 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Vera Hoke

6 DATE OF BIRTH (month, day, and year) May 21st 1884

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|---|
| | 42 | 9 | 28 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) B. C. A. A.

(c) Name of employer

9 BIRTHPLACE (city or town) Md

(State or country) Baltimore. Md

PARENTS

10 NAME OF FATHER Samuel ? Hoke

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Hoke

13 BIRTHPLACE OF MOTHER (city or town) Baltimore. Md

(State or country)

14 Informant Wife Vera 2658 Frederick ave

(Address)

15 Filed JAN 19 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 17, 1927, to Jan 18, 1927, that I last saw h alive on Jan 18, 1927, and that death occurred, on the date stated above, at 2 30 P.M.

The CAUSE OF DEATH* was as follows:

Perforated Gastric Ulcer

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18 Where was disease contracted ?

If not at place of death? ?

Did an operation precede death? Yes Date of Jan 18 1927

Was there an autopsy? Yes

What test confirmed diagnosis? Operative diagnosis

(Signed) A J Knapp M. D.

1-18, 1927. (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery Date of Burial Jan 21st 1927

20 UNDERTAKER J. A. Hilpert ADDRESS 1150 W Baltimore St

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 18076

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 18076

1-PLACE OF DEATH

REGISTERED NO. 152

CITY OF BALTIMORE: (No. 407 Furrow ST., 2069 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clifton Leroy Bowen

(a) RESIDENCE NO. 407 Furrow St. ST., 20th WARD

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 10th. 1926

| 7 AGE Years | Months | Days | If LESS than 1 day, ... hrs or ... min |
|---|---|---|---|
| | 3 | 7 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ...

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer ...

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Clifton R. Bowen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Emma E. Schaefer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Clifton R. Bowen
(Address) 407 Furrow St.

15 Filed JAN 19 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 17, 1927

17

I HEREBY CERTIFY, That I attended deceased from November 16, 1926, to Jan. 17, 1927

that I last saw him alive on Jan 17, 1927

and that death occurred, on the date stated above, at 9 A.m.

The CAUSE OF DEATH* was as follows:

Tetany 2 Mos.
Furunculosis

(duration) yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) E. Pavlatica M. D.

1/18, 1927 (Address) 24 N. Fulton Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery DATE OF BURIAL 1/19, 1927

20 UNDERTAKER J. A. Wolfgang ADDRESS 1850 N. Bals se

Spec.—7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18077

## CERTIFICATE OF DEATH

109-002

15-63

E 18077

1-PLACE OF DEATH

City of BALTIMORE: (No. 3713 Kate. Ave St., Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doris. M. Steinhold

(a) RESIDENCE NO. 3713 Kate Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 11 mos. 12 ds. How long in U. S. If nf foreign birth, yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE nf

6 DATE OF BIRTH (month, day, and year): February 5 1921

7 AGE: Years 5 Months 11 Days 12 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city nr town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER John. F. Steinhold

11 BIRTHPLACE OF FATHER (City or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Sophia. L. Petry

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Mr. John F. Steinhold (Address) 3713 Kate Ave

15 Filed JAN 19 1927 C. HAMPSON JONES, M. D., Registrar Per R.M.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 4 1924 to Jan 18 1927 that I last saw h[illegible] alive on Jan 17 1927 and that death occurred, on the date stated above, at 5.20 a m.

The CAUSE OF DEATH* was as follows:

Staphylococcus Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Tonsilitis (staphylococcus shown)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? , Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Wolfe Story M. D.

(Address) 7 E Franklin & Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery Date of Burial Jan 20 1927

20 UNDERTAKER: Henry Hoeck Son ADDRESS 1301 E Eager St

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 18078

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

10-14 185

REGISTERED No. E 18078

1-PLACE OF DEATH

City of BALTIMORE: (No. St Joseph Hospital St. 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George G. Harrison

(a) RESIDENCE NO. 938 E. Biddle St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | white | married |

5a If married, Widowed, or divorced HUSBAND of (or) WIFE of Fannie C. Harrieson

6 DATE OF BIRTH (month, day, and year) April 4/1868

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 58 | 9 | 13 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer 030

(b) General nature of industry business, or establishment in which employed (or employer) Calvert Building

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Washington D.C.

PARENTS

10 NAME OF FATHER Robert E. Harrison

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Mary M. Green

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto. Md.

14 Informant Mrs. Fannie C. Harrison

(Address) 938 E. Biddle

15 Filed JAN 19 1927 C. HAMPSON JONES, M. D. Registrar

Per RR

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intracranial Hemorrhage- Accidently fell to sidewalk & fractured skull

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. W. Bates M. D.

(Coroner)

1/19/27 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery Date of Burial Jan 20 1927

20 UNDERTAKER Henry Steed Son ADDRESS 1301 E Eager St

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

Anna Poncet

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18079

## CERTIFICATE OF DEATH.

E 18079

REGISTERED NO. 179

1-PLACE OF DEATH

City of BALTIMORE: (No. Almshouse Dept St. 17-25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Poncet

(a) RESIDENCE NO. 7116 Leeds St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | W | W Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Matthew Poncet

6 DATE OF BIRTH (month, day, and year) unk

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| About | 72 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland

(State or country)

PARENTS

10 NAME OF FATHER Bernard Bunck

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Penz

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mr Jos W Busch

(Address) 639 N Robinson St

15 Filed JAN 19 1927 G. HAMPTON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/17/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Chronic Valvular Disease of Heart (Accidental)

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Samuel A Levy, M. D. (Coroner)

, 1927 (Address) 225 Bath St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore County Date of Burial Jan. 20 1927

20 UNDERTAKER Henry Hoerdt Son ADDRESS 1301 E Eager St

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18080

## CERTIFICATE OF DEATH.

85 E 18080

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1201 S. Sharp St. 21-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edith V. Sheckels.

(a) RESIDENCE NO. 947 S. Paca St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. 7 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female. | White. | Married. |

3a If married, widowed or divorced (or) WIFE of Fletcher J. Sheckels.

6 DATE OF BIRTH (month, day, and year) June 6, 1884.

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 42 | 7 | 11 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sewing machine operator.

(b) General nature of industry, business, or establishment in which employed (or employer) Phoenix Mfg. Co.

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER William Swanner.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Margaret Saunders.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland.

14 Informant Fletcher J. Sheckels. (husband)

(Address) 947 S. Paca St.

15 Filed ..... 19.. C. HAMPSON JONES, M. D. Registrar

JAN 19 1927 Per

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 17, 1927 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull.

Accidental fall into elevator pit.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Ehrhardt, M. D. (Coroner)

1/18, 19 27 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death..... yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem. Date of Burial Jan 20 1927

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 W. Balto St.

very important. See instructions on back of certificate. Exact statement of OCCUPATION is

Spec.—1-12 23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 18081

## CERTIFICATE OF DEATH.

E 18081

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3511 Greenmount Ave., ST., 9-47 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Mary Griffin

(a) RESIDENCE No. 3511 Greenmount Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred [illegible] mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martin J. Griffin

6 DATE OF BIRTH (month, day, and year) Dec. 12, 1854

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 72 | 1 | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Edinburgh (State or country) Scotland

PARENTS

10 NAME OF FATHER James Penniman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Janet Cowason

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant James B. Griffin (Address) 3511 Greenmount Avenue

15 Filed JAN 19 1927 19 C. HAMPSON JONES, M. D. Registrar

By [signature]

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 18 19 27

17 I HEREBY CERTIFY, That I attended deceased from Jan 2 1927 to Jan 18 1927

that I last saw her alive on, Jan 17 1927

and that death occurred, on the date stated above, at 9.30 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) Hypocardia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Physical signs

(Signed) W. H. Pearce M. D.

Jan. 18 1927 (Address) 2105 North Charles Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Jan 21 1927

20 UNDERTAKER Joseph B Cook

ADDRESS 1003 N Gilmor St

SEE INSTRUCTION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# E 18082 HEALTH DEPARTMENT—CITY OF BALTIMORE E 18082

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. 33 E Calvert St.) 12-49 (WARD)

REGISTERED NO. 86

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ralph M Sipes (Sipes)

(a) RESIDENCE NO. Hyder - Balto. Co. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Alice Sipes

6 DATE OF BIRTH (month, day, and year): July 31, 1904

7 AGE: Years 22 | Months 5 | Days 15 19 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer): Produce

(c) Name of employer: Consolidated Ice Co. - Chester St.

9 BIRTHPLACE (city or town) (State or country): Randallstown - Balto. Co.

PARENTS

10 NAME OF FATHER: Roy Sipes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Randallstown - Balto. Co.

12 MAIDEN NAME OF MOTHER: Elma Gittridge

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Topeka, Kansas

14 Informant: Roy M. Sipes (Address): Hyde Md.

15 FILED: JAN 19 1927 C. HAMPSON JONES, M. D. Registrar Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 19, 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 11, 1927, to Jan 19, 1927, that I last saw him alive on Jan 19, 1927, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Encephalitis

(duration) yrs. mos 2 1 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Jan 11, 1927

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Norman M. Hunter, M. D.

1/19 1927 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cem (Cooksville Md) DATE OF BURIAL: Jan 22 1927

20 UNDERTAKER: Joseph B Cook ADDRESS: 1003 W Balto St

Spec.—8-24-14—M. & T.—2000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18083 E 18083

## CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 504 East ST. 7-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H. Queen

(Residence in Baltimore: No. 504 East St St.; Life yrs. mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widower

6-DATE OF BIRTH, Dec 5 (Month) (Day) 1855 (Year)

7-AGE. 71 yrs. mos. ds.

If LESS than 1 day, ....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE. (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country) unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country) unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Emma Harris

(Address) 524 East St

15- JAN 19 1927 HAMILTON JONES, M. D. Registrar.

Per .....

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 1-16-27 (Month) (Day), 191... (Year)

17- I HEREBY CERTIFY, That I attended deceased from 1-6-27 191..., to 1-17-27 191..., that I saw h[illegible] alive on ..." 191..., and that death occurred, on the date stated above, at 5 40 [illegible].

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) 1 yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Senility

(Duration) yrs. mos. ds.

(Signed) H. Richardson M. D.

1-18-27, 191... (Address) 1524 N. Bond Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem. DATE OF BURIAL, 1-20-27

20-UNDERTAKER J. Lucien Hall ADDRESS 523 Dolphin St

Spec.—12-23-21—E.B.R.S.—400 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18084

## CERTIFICATE OF DEATH.

1629

E 18084

1-PLACE OF DEATH

City of BALTIMORE: (No. 2909 Mosher St. 16-68 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Michael J. Doyle.

(a) Residence No. 2909 Mosher St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 9 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Morgan Doyle

6-DATE OF BIRTH (month, day and year) April 18, 1856

7-AGE. 70 yrs. 9 mos. 0 ds. If LESS than 1 day, ....hrs. or....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired 7 yrs - 1
(b) General nature of industry, business, or establishment in which employed (or employer) carpenter + 015
(c) Name of employer Builder

9-BIRTHPLACE (city or town) Balto, Md -
(State or Country),

PARENTS.

10-NAME OF FATHER, Wm H. Doyle.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland -

12-MAIDEN NAME OF MOTHER, Margaret Kindelay

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland -

14- (Informant) Miss Ruth Doyle
(Address) 2909 Mosher St

15- Filed JAN 9 1927. HAMPSON JONES, M. D. Registrar.
By

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 17, 1927

17- I HEREBY CERTIFY, That I attended deceased from Jan. 8, 1927 to Jan 17, 1927
that I last saw him alive on Jan 17, 1927
and that death occurred, on the date stated above, at 9 40 P. m.
The CAUSE OF DEATH* was as follows:
arteriosclerosis chronic interstitial nephritis
myocarditis
about 3-4 yrs —
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) terminal pneumonia
(Duration) yrs. mos. 12 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? general -

(Signed) George A Knapp M. D
, 19 (Address) 3030 Edmondson Ave -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| PLACE OF BURIAL, CREMATION OR REMOVAL. | DATE OF BURIAL. |
|---|---|
| New Cathedral Cem | Jan 20 1927 |
| 20 UNDERTAKER Edw J Lennon & Son | ADDRESS 901 N Howard St |

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18085

## CERTIFICATE OF DEATH

E 18085
REGISTERED NO.

1-PLACE OF DEATH Woman's Hospital

City of BALTIMORE: (No. John & Fayette — St., 16-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Rees.

(a) RESIDENCE NO. 3311 Toone St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Mr. Simon Rees.

6 DATE OF BIRTH (month, day, and year): ? 1854

7 AGE: Years 73 Months Days IF LESS than 1 day ... hrs. or ... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Wales.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Mr Simon Rees

(Address) 3311 Toone

1927 C. HAMPSON JONES, M. D. Registrar

Per HRR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 17, 1927.

17 I HEREBY CERTIFY, That I attended deceased from Dec. 5, 1926, to Jan. 17, 1927, that I last saw h[illegible] alive on Jan. 17, 1927, and that death occurred, on the date stated above, at 2:25 P m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis

cerebral hemorrhage

(duration) yrs. mos. 45 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 22 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) Wm. W. Love, M. D.

, 19 (Address) Women's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cem — Date of Burial 1-20 1927

20 UNDERTAKER: Robert Brooks & Son — ADDRESS Catonsville

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18086

## CERTIFICATE OF DEATH.

44

E 18086

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. _____ St. 12-20 Ward)

2-FULL NAME George D Alexander

(a) RESIDENCE NO. 2011 Maryland Ave St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widowed |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1857

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 70 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) gb

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Tenn.

PARENTS

10 NAME OF FATHER William F. Alexander

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Tenn.

12 MAIDEN NAME OF MOTHER Virginia Anderson

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Tenn.

14 Informant ALS

(Address) Records,

15 Filed 9 1927 19 Per _____ Registrar

C. HANSON JONES, M. D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 18 1927

17

I HEREBY CERTIFY, That I attended deceased from July 10, 1926, to January 18, 1927, that I last saw him alive on January 18, 1927, and that death occurred, on the date stated above, at 12.30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? General & Laboratory

(Signed) R. Hooper Smith, M. D.

Jan. 19 27 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hagerstown Md — Date of Burial: 1/22 1927

20 UNDERTAKER: Robert Brookerson — ADDRESS: Calhoun & Hollins St

very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18087 E 18087

## CERTIFICATE OF DEATH.

162

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1359 Stockton ST. 15-23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Jackson

(a) RESIDENCE No. 1359 Stockton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 12 hours *How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Black

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1/17/27

7 AGE Years Months Days If LESS than 1 day hrs. 12 or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Arthur Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Beatrice Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Beatrice Jackson

(Address) 1359 Stockton St.

15 Filed JAN 19 1927, 19 C. HAMPSON JONES M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-18 1927

17 I HEREBY CERTIFY, That I attended deceased from 4/17, 1927 to 1/18, 1927 that I last saw her alive on 1/17, 1927 and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Asphyxia

Congenital atelectasis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis?

(Signed) M. Alexander Morey, M. D.

1927, 19 (Address) 1516 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19 1927

20 UNDERTAKER

ADDRESS

C. Hampson Jones M. D. Commissioner of Health

JAN 19 1927

TION is very important See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Pks.

E 18088

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18088

## CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH

City of BALTIMORE: (No. 26-37 St., Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George H. Hollins

(a) RESIDENCE NO. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widowed |

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1847

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 80 80 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) On shipboard

(State or country) at Sea

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant

(Address) Records

15 [illegible] 19 [illegible]

[illegible] Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 12 1927

17

I HEREBY CERTIFY, That I attended deceased from October 25, 1926, to January 12, 1927, that I last saw him alive on January 11, 1927, and that death occurred, on the date stated above, at 5-45 A m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

Myocardial Insufficiency & hypertrophy

Pleural Effusion (cardiac)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Lesions

(duration) yrs. mos. 7 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? general & laboratory

(Signed) R. H. Hooper Smith, M. D.

Jan 12 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Interred and shipped to Phila. Pa Feb 3 1927

20 UNDERTAKER Wm Cook ADDRESS 502 E. Monument

Commissioner Health

JAN

Spec.—8-24-14—M. & T.—2000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18089 E 18089

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 228 W. Lanvale St. 11-25 WARD) REGISTERED No. C 100-001

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Sarah Rogers Mommonier

(Residence in Baltimore: No. 228 W. Lanvale St.; Lifetime yrs., mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

| 3-SEX. | 4-COLOR OR RACE. | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) |
|---|---|---|
| Female | White | Widow |

6-DATE OF BIRTH, June (Month) 11 (Day), 1847 (Year)

7-AGE, 80 yrs. — mos. 11 ds. If LESS than 1 day, ....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Lady
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Baltimore Co. Maryland

PARENTS.

10-NAME OF FATHER, Francis B. Lanahan

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Co. Md

12-MAIDEN NAME OF MOTHER Elizabeth Carroll

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Co. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Sarah Mommonier

(Address) 228 W. Lanvale St.

15- Nov 9 1927 191... C. HAMPSON JONES M.D. Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 18 (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 7 1927, to June 18 1927, that I saw h[illegible] alive on June 17 1927, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(Duration) ....yrs. ....mos. 7 ds.

(Signed) Alfred J. Carmody M. D.

June 18, 1927. (Address) 1 West Chase St Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

| 19-PLACE OF BURIAL OR REMOVAL, | DATE OF BURIAL, |
|---|---|
| Cathedral Cemetery | 11 20 —, 1927 |
| 20-UNDERTAKER | ADDRESS |
| Chas. L. Crane & Son | 11 W. Mt. Royal Ave |

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18090 E 18090

## CERTIFICATE OF DEATH

161-001

REGISTERED NO. 15-68

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Macatee

(a) RESIDENCE NO. 2804 Walbrook St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 18 1927

| 7 AGE | Years | Months | Days | IF LESS than 1 day ...hrs. or ...min.. |
|---|---|---|---|---|
| 2 days | | | 2 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Walter D. Macatee

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER Henriette Webster

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Harford Co

14 Informant Mr Macatee 2804 Walbrook

(Address)

15 Filed 1927 C. HAMPSON JONES, M. D.

Per Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 18, 1927, to Jan 19, 1927, that I last saw h[illegible] alive on Jan 19, 1927, and that death occurred, on the date stated above, at 1[illegible] m.

The CAUSE OF DEATH was as follows:

Prematurely

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Mary's Sileville Ba. Co. Date of Burial: Jan. 20, 1927

20 UNDERTAKER: Martin Bailey & Sons ADDRESS: 1827 Pennsylvania

very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18091

E 18091

# CERTIFICATE OF DEATH

161-001

15-67

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hosp St. 12 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Macatee

(a) RESIDENCE NO. 2804 Walbrook St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. hrs. 4 da. How long in U. S. If of foreign birth? yrs. mos. da.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 18, 1927

| 7-AGE | Years | Months | Days | IF LESS than 1 day 4 hrs. or min.. |
|---|---|---|---|---|
| 4 hrs | | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Walter F. Macatee

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Harford Co.

12 MAIDEN NAME OF MOTHER Henrietta Webster

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Harford Co

14 Informant Mr Walter Macatee

(Address)

C. HARPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Jan 18, 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 18, 1927, to Jan 18, 1927,

that I last saw him alive on Jan 18, 1927,

and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Premature Birth

Breech Presentation

(one of twins)

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. J. Knapp, M. D.

(Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

St. Mary's Pikesville Ba. Co.

Date of Burial Jan. 20 1927.

20 UNDERTAKER Martin Bahy & Sons

ADDRESS 1827 N. North Ave

very important. See instructions on back of certificates.

1 9 1927

Spec.—12-9-25—A Co.—200 Blks.

(Rinn)

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

E 18092

# CERTIFICATE OF DEATH.

E 18092

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Mercy Hospital

City of BALTIMORE: (No. 9-46 St., Ward)

2-FULL NAME William A. Rinn

(a) RESIDENCE NO. 803 E. 22 St., St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary E. Rinn.

6 DATE OF BIRTH (month, day, and year): Jan 3, 1870

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 57 | 0 | 16 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: retired Salesman

(b) General nature of industry, business, or establishment in which employed (or employer): Machinery Supply

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: John S. Rinn

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Ireland.

12 MAIDEN NAME OF MOTHER: Sarah Burns.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Washington D.C.

14 Informant: Mary E. Rinn

(Address): 803 E. 22 St.

15 Filed JAN 9 1927 C. HAMPSON JONES, M. D., Registrar

By

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 16, 1927, to Jan 19, 1927

that I last saw h[illegible] alive on Jan 19, 1927 at 12:30 P.M.

and that death occurred, on the date stated above, at [illegible] M.

The CAUSE OF DEATH* was as follows: Hypertension

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem

Date of Burial: 1/22 1927

20 UNDERTAKER: Mary M. Widefield

ADDRESS: 501 E. 22 St.

very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

# E 18093 HEALTH DEPARTMENT—CITY OF BALTIMORE E 18093

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1102 W Lafayette Ave St., 16 Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Landrew J Davis

(a) Residence No. 1102 W Lafayette Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE. White

5-~~Single,~~ Married, ~~Widowed, or Divorced.~~ (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Emma L Davis

6-DATE OF BIRTH (month, day and year) Jan 1843 ~~1845~~ CM

7-AGE. 83 Yrs 3 mos. 9 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Co. Va

PARENTS.

10-NAME OF FATHER, Wm. Davis

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Va

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Va ?

14- (Informant) Emma L Davis

(Address) 1102 W Lafayette Ave

15- Filed Jan 19 1927 C. HAMPSON JONES, M. D. Registrar.

Per

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 18 1927

17- I HEREBY CERTIFY, That I attended deceased from Jan 14 19 , to Jan 18 19 27

that I last saw him alive on Jan 16 19 27

and that death occurred, on the date stated above, at 10

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

Old age

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) , M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore DATE OF BURIAL, Jan 20 1927

20-UNDERTAKER, William Cook ADDRESS 92 E North Ave

Spec.—6-9-19—H. P. Co.—1000 Blks.

E 18094 HEALTH DEPARTMENT—CITY OF BALTIMORE E 18094

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 3403 Galloway Ave ST. 15-62 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara Wilson Blamberg

(a) RESIDENCE. No. 3403 Galloway Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Richard Lee Blamberg.

6 DATE OF BIRTH (month, day, and year) Jan 5-1894

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 33 | 0 | 12 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER John F. Eronhardt.

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Wilson

13 BIRTHPLACE OF MOTHER (city or town) Va. (State or country)

14 Informant Richard Lee Blamberg
(Address) 3403 Galloway Ave.

FILED 9 1927 C. HAMPSON JONES, M. D. Registrar
Per

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 17 1927

17 I HEREBY CERTIFY, That I attended deceased from August 27, 1919, to January 17, 1927, that I last saw her alive on January 17, 1927, and that death occurred, on the date stated above, at 6:30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 9 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Tubercle bacilli in Sputum

(Signed) Charles R. Austrian, M. D.

, 19 (Address) 1417 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery. DATE OF BURIAL Jan 20 1927

20 UNDERTAKER Hughes & Jones Inc ADDRESS 424 N. Howard

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18095 E 18095

## CERTIFICATE OF DEATH.

REGISTERED NO. 16-68 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2857 Prospect ST. WARD)

2-FULL NAME Robert S Deal

(a) RESIDENCE NO. 2857 Prospect ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Maggie E Deal

6 DATE OF BIRTH (month, day, and year): Nov 5 1865

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 61 | 2 | 12 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Brass 047

(b) General nature of industry, business, or establishment in which employed (or employer): Moulder

(c) Name of employer: Liberty Brass Co

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: John T Deal

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Rebecca Wilcox

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Maggie E Deal

(Address) 2857 Prospect St

15 Filed 1 9 1927 H. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 17 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1927, to Jan 17, 1927, that I last saw him alive on Jan 17, 1927, and that death occurred, on the date stated above, at 4.05 m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

Interstitial

Hypertension

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary): Uraemia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Jack R. Hollis, M. D.

, 19 (Address) 2838 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Jan 20 1927

20 UNDERTAKER: Wilbur Leach & Son — ADDRESS: Franklin

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18096

## CERTIFICATE OF DEATH.

1827 E 18096

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St. 1-2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Manuel Mezzo.

(a) RESIDENCE NO. 640 S. Lemmon St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) December 31 1876

7 AGE: Years 50 Months Days 20 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Italy

PARENTS

10 NAME OF FATHER Luigi Menna

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Italy

12 MAIDEN NAME OF MOTHER Incgalla Renzi

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Italy

14 Informant Luigi Menna

(Address) Problem Road Elwood

15 Date 1927 C. HAMPSON JONES, M. D.

Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry,) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acc Fall.

Fracture of Skull 3 hrs

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Shock

(Duration) ..... yrs. ..... mos. 1 ds.

Jan 18 1927 (Signed) H. C. Yates M. D.

(Coroner)

, 19 (Address) 142 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — Date of Burial: Jan 20 1927

20 UNDERTAKER: Wendell Diffendoon — ADDRESS 37 [illegible]

Very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

E 18097

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 18097

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. [redacted] St. 7-13 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Nelkowski

(a) RESIDENCE NO. 1616 Dawns Lt St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced RUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1842

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 85 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist 31

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant (Address) Records

BALTIMORE CITY HOSPITALS

15 1927 C. HAMPSON JONES, M. D.

Registrar

Per [redacted]

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 18 1927

17

I HEREBY CERTIFY, That I attended deceased from August 20, 1925, to January 18, 1927, that I last saw h[redacted]m alive on January 15, 1927, and that death occurred, on the date stated above, at 3 20 P m.

The CAUSE OF DEATH* was as follows:

Senility

Cortical Sclerosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? General & Laboratory

(Signed) [redacted] M. D.

Jan 19 27 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross German Hill Date of Burial Jan 21 1927

20 UNDERTAKER Wendell Oppel & Son ADDRESS 378 N

Very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 18098

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18098

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (NO. ..... ST., 7-4 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John B. Lewis

(a) RESIDENCE NO. Newport - Tenn ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 5 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jane Lewis

6 DATE OF BIRTH (month, day, and year) 1865

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs or ... min. |
|---|---|---|---|---|
| 62 | | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Tenn -

PARENTS

10 NAME OF FATHER Elijah Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C

12 MAIDEN NAME OF MOTHER .....

13 BIRTHPLACE OF MOTHER (city or town) (State or country) .....

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

9 1927 C. HAMPSON JONES, M. D.
Registrar
Per Reed

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18 1927

17 I HEREBY CERTIFY That I attended deceased from Jan 13th, 1927, to Jan 18th, 1927, that I last saw h(im) alive on Jan 18, 1927 and that death occurred, on the date stated above, at 9:40 P m.

The CAUSE OF DEATH* was as follows:

Emphysema; Arteriosclerotic heart disease; Myocardial failure

Unknown (duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ... yrs. ... mos. 4 ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-rays & Physical Examination

(Signed) Milton Shiers, M. D.

, 19 (Address) Johns Hop. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Newport, Tenn

DATE OF BURIAL Jan 20 19 27

20 UNDERTAKER William B. Schaffer

ADDRESS 1816 Monument

Spec.—1-12-23—M&T—500 Bks.

Trew

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18099

## CERTIFICATE OF DEATH.

E 18099

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 40 South Schroeder St. 18-29 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Trew

(a) RESIDENCE NO. 40 South Schroeder ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 19" 1922

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs or ... min. |
|---|---|---|---|---|
| 5 | | --- | --- | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Arthur Trew

11 BIRTHPLACE OF FATHER (city or town) Fort Leavenworth
(State or country) Kansas

12 MAIDEN NAME OF MOTHER Sophia Miller

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mrs. Arthur Trew
(Address) 40 S. Schroeder St.

15 Filed ... 19...

20 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 19" 19 27

17 I HEREBY CERTIFY, That I attended deceased from 1/18/27, 19..., to 1/19/27, 19..., that I last saw her alive on 1/19/27, 19..., and that death occurred, on the date stated above, at 4.40 A. m.

The CAUSE OF DEATH* was as follows:

Pertussis

History ... yrs. 2 mos ... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Bernard J. Fenny, M. D.

1/19, 19 27 (Address) 910 W. Lombard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| London Park Cem | Jan 28, 19 27 |
| 20 UNDERTAKER Joseph B Cook | ADDRESS 1003 W Balto St |

Spec.—1-12-23—M&T—500 Blks.

E 18100 HEALTH DEPARTMENT—CITY OF BALTIMORE E 18100

CERTIFICATE OF DEATH

1-PLACE OF DEATH St. Josephs Hospital. REGISTERED NO. 9-17

CITY OF BALTIMORE: (No. ..... ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Ann Orendorff.

(a) RESIDENCE NO. Westminster, Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 25 1855

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 71 | 6 | 24 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Westminster (State or country) Carroll County, Md.

PARENTS

10 NAME OF FATHER John J. Baumgartner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Switzerland

12 MAIDEN NAME OF MOTHER Margaret A. Leister

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Switzerland

14 Informant (Address) Westminster Md

15 Filed JAN 20 1927 19 C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov. 2, 1926. to Jan. 19, 1927

that I last saw her alive on Jan. 19, 1927

and that death occurred, on the date stated above, at 11 30 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Descending Colon

(duration) 8-10 yrs. mos ds.

CONTRIBUTORY (Secondary) Starvation.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. L. McAuley, M. D.

19 (Address) St. Josephs Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| St John Westminster | 1/22 1927 |
| 20 UNDERTAKER H Bankard & Son | ADDRESS Westminster Md |

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18101

## CERTIFICATE OF DEATH.

181-001

E 18101

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. E 124 S P Pk Ave 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James H. Clarke

(a) RESIDENCE NO. 124 S P. Pk. Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna Clarke

6 DATE OF BIRTH (month, day, and year): Sept. 16-1859

7 AGE: Years 67 Months 3 Days 1 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer

9 BIRTHPLACE (city or town): Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER: Martin Clark

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Va.

12 MAIDEN NAME OF MOTHER: Junk Farrell

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md.

14 Informant: John Clarke

(Address): 124 S P. Pk. Ave

Filed NOV 20 1927 C. HAMPSON JONES, M. D. Registrar

Per

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 17 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cor. Pneumonia

Lt. Lob.

(duration) yrs. mos. 4 hrs

CONTRIBUTORY (Secondary) Cerebral Hem

(duration) yrs. mos. 1 ds.

(Signed) C. C. Pfeltz M. D.

(Coroner)

1927 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Old St Patricks Date of Burial 11-20 1927

20 UNDERTAKER: John A Moran ADDRESS: 3010 Balto St.

Cor.—12-9-25—A Co.—200 Bks.

E 18102

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

100-001

E 18102

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 931 Mulberry St. 18-26 Ward)

2-FULL NAME Evelyn Hudson

(a) RESIDENCE NO. 931 Mulberry St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Divorced

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 23, 1874

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | | 8 | 25 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town): Balto City

(State or country): Md

PARENTS

10 NAME OF FATHER: Philip Hudson

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Pa

12 MAIDEN NAME OF MOTHER: Amelia Williams

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Pa

14 Informant: Philip Hudson

(Address): 931 W Mulberry St

15 Filed: 1-19 1926 By C. HARRISON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1-15 1926

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Bronchopneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Samuel T. Earle M. D. (Coroner)

, 19 (Address) 1022 East Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Date of Burial: Jan 20 1926

20 UNDERTAKER: David Easton ADDRESS 54 ms

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18103

## CERTIFICATE OF DEATH

E 18103
REGISTERED NO.

1-PLACE OF DEATH Balto City Hospitals
CITY OF BALTIMORE (No.) Balto Md ST., 17-25 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Minor

(a) RESIDENCE NO. 617 Pierce Av ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: Blk.
5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE — Years: 70 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer): None
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS
10 NAME OF FATHER: Unknown
11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown
12 MAIDEN NAME OF MOTHER: Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Balto City Hosps.
(Address) Balto Md.

15 JAN 20 1927 C. HAMPSON JONES, M. D.
Registrar
By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-18 1927

17 I HEREBY CERTIFY, That I attended deceased from 7-23- 1926 to 1-18 1927
that I last saw her alive on 1-18 1927
and that death occurred, on the date stated above, at 2 P. m.
The CAUSE OF DEATH* was as follows:

Terminal Bronchopneumonia
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Senile Psychosis with Deterioration
(duration) mos. ds.

18 Where was disease contracted if not at place of death? Unknown
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) Harry Schmidt M.D.
1/19/1927 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn
DATE OF BURIAL: Jan 20/27

20 UNDERTAKER: Hamil Easton
ADDRESS: Balto

Cor.—12-9-25—A Co.—200 Bks.

E 18104

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-002

## CERTIFICATE OF DEATH.

REGISTERED NO. E 18104

1-PLACE OF DEATH

City of BALTIMORE: (No. 208 S Dallas St., 3-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Geo. Howard

(a) RESIDENCE NO. 208 S Dallas St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | colord | single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 10-1926

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | | 10 | 7 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto City

PARENTS

10 NAME OF FATHER Geo Howard

11 BIRTHPLACE OF FATHER (city or town)

(State or country) va

12 MAIDEN NAME OF MOTHER Lucie Holland

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) md

14 Informant Geo Howard

(Address) 208 S Dallas St

15 Filed Jan 20 1927 C. HAMPSON JONES, M. D.

Per Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cap. Bronchitis

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) yrs. mos. 1 ds.

(Signed) J. C. Price M. D.

(Coroner)

Jan 19 1927 (Address) 1431 E Oliver

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem Date of Burial Jan 20 1927

20 UNDERTAKER Henry Foster ADDRESS Paca

Cor.—12-9-25—A Co.—200 Bks.

E 18105

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18105

## CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 23-31 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dorothea Moore

(a) RESIDENCE NO. 1036 Sharp St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | col | single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of XXXXXX

6 DATE OF BIRTH (month, day, and year) July 29/20

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | | 5 | 19 20 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Geo Moore

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Lillian Jones

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Geo Moore

(Address) 1036 Sharp St

1927 C. HAMPSON JONES, M. D.

By K H Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia (Lobar)

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) J. H. Bates, M. D.
(Coroner)

1/19/27 (Address) 508 E. North Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Date of Burial Jan 20 27

20 UNDERTAKER John H. Toadvin ADDRESS 1027 Hand Ave

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18106

## CERTIFICATE OF DEATH

E 18106

REGISTERED NO. 57

1-PLACE OF DEATH

City of BALTIMORE: (No. Provident Hos St. 3-5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucille Benton

(a) RESIDENCE NO. 915 Watson St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Colored | married |

5a If married, widowed or divorced HUSBAND of (or) WIFE of Seth Benton

6 DATE OF BIRTH (month, day, and year) 1896

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs or min. |
|---|---|---|---|---|
| 31 | 30 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 03

(c) Name of employer

9 BIRTHPLACE (city or town) Va.

(State or country)

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) unknown

PARENTS

14 Informant Seth Benton

(Address) 915 Watson St

15 Filed JAN 20 1927 C. HAMPTON JONES, Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 15 1927 to Jan 19 1927

that I last saw her alive on Jan 18 1927

and that death occurred, on the date stated above, at 3.45 a. m.

The CAUSE OF DEATH* was as follows:

Cerebella Hemorrhage

(duration) unknown yrs. mos ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Lab. & Clinical

(Signed) Bernard Stamm M. D.

19 (Address) 384 Carlton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wheatleyville Va. DATE OF BURIAL Jan 21 1927

20 UNDERTAKER Chas. N. Johnson ADDRESS 4464 Carlton

Very important. See instructions on back of certificates.

Trapp.

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18107 / 40 E 18107

## CERTIFICATE OF DEATH

1-PLACE OF DEATH Colonial Hospital 2 REGISTERED NO.

City of BALTIMORE: (No. 16 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Myrtle Trapp.

(a) RESIDENCE NO. 1104 Woodley St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred / yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Arthur Trapp

6 DATE OF BIRTH (month, day, and year): Aug. 14, 1903

7 AGE: Years 23 Months 5 Days 5 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Benton Ark.

(State or country)

PARENTS

10 NAME OF FATHER: Edward King

11 BIRTHPLACE OF FATHER (City or town) Benton Ark.

(State or country)

12 MAIDEN NAME OF MOTHER: Mattie Abercrombie

13 BIRTHPLACE OF MOTHER (city or town) Benton Ark.

(State or country)

14 Informant: Arthur Trapp

(Address) 1104 Woodley St.

15 Filed NOV 20 1927 Per

C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 January 19, 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 12, 1927 to Jan 19, 1927.

that I last saw ~~him~~ alive on Jan 19, 1927

and that death occurred, on the date stated above, at 1.45 A m.

The CAUSE OF DEATH* was as follows:

Tuboovarian abscess

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) General Peritonitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? Yes Date of 1-18-27

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab

(Signed) J. Tulla M.D., M. D.

1-19-1927 (Address) 1122 N. Mount St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Benton Arkansas — Date of Burial 1/20 19

UNDERTAKER: Margaret J. Flynn — ADDRESS 1422 Light St

Very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18108

## CERTIFICATE OF DEATH.

E 18108

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3429 Pinna. Ave. ST. 13-59 WARD)

REGISTERED NO. 49

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Yetta Wzinberg

(a) RESIDENCE NO. 3429 Pinna. Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: David Wzinberg

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 49; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: David Goodman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Rachael -

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: David Wzinberg

(Address): 3429 Pinna. Ave.

Date received JAN 20 1927

H. HARRISON JONES, M. D.

Registrar

By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): January 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec. 30, 1926, to Jan. 19, 1927,

that I last saw her alive on Jan. 18 1927

and that death occurred, on the date stated above, at 9.45 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the breast

(duration) 3 yrs. 6 mos ds.

CONTRIBUTORY (Secondary): General malignancy

(duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Sept 28, 1923

Was there an autopsy? no

What test confirmed diagnosis? clinical & pathologic

(Signed) M M Guttemon, M. D.

Jan 19 1927 (Address) 3110 Reisterstown Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Herrn Rm

DATE OF BURIAL: 1/20 1927

20 UNDERTAKER: Jack Lewis

ADDRESS: 1439 Eutaw St

Bass -

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

# CERTIFICATE OF DEATH.

E 18109 — REGISTERED NO. E 18109

1-PLACE OF DEATH Mercy Hospital

City of BALTIMORE: (No. 15-58 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abram Bass

(a) RESIDENCE NO. 2805 Druid Hill Ave, Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S. if of foreign birth? 20 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| M | White | Married |

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha Bass

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 45 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor 080

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Jack Lewis

(Address) 1439 E Balt St

15 Filed NOV 20 1927 H. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 14, 1927, to Jan 19, 1927

that I last saw him alive on Jan 19, 1927,

and that death occurred, on the date stated above, at 1:00 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R. Wells, M. D.

1/19, 1927 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — Date of Burial 1/20 1927

20 UNDERTAKER Jack Lewis — ADDRESS 1439 E Balt St

NOV 20 1927 By K.E.

Spec.—1-10-21—M&T—1500 Bks.

18110

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129 E 18110

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 17 S Bond St., 3-4 WARD)

2-FULL NAME Joseph G Schwarzkopf

(a) RESIDENCE NO. 1518 E Pratt St WARD 9

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 1 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anne Schwarzkopf

6 DATE OF BIRTH (month, day, and year): Nov. 30 1861

7 AGE: 65 Years 1 Months 19 Days. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Saloon keeper

(b) General nature of industry, business, or establishment in which employed (or employer): 044

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: William Schwarzkopf

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth Groh

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Catharine Baumeister

(Address) 17 S Bond St

Jan 20 1927. 19 C. HAMPTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 18 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan. 17 1927 to Jan 18 1927.

that I last saw him alive on Jan. 18 1927.

and that death occurred, on the date stated above, at 10 16 a m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary): Chronic Interstitial Nephritis and Cardiac Hypertrophy, Cause Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1518 E. Pratt St

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) A. T Reis, M. D.

Jan 19 1927 (Address) 24 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: Jan 21 1927

UNDERTAKER: Louis Heemann — ADDRESS: 32 S Broadway

FOR A very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

Staewen

# HEALTH DEPARTMENT—CITY OF BALTIMORE

57

E 18111

## CERTIFICATE OF DEATH.

E 18111

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1822 N. Port St St., 8-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma K. Staewen

(a) RESIDENCE NO. 1822 N. Port St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. mos. ds. (If non-resident give city and State) How long in U. S., if of foreign birth 56 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced WIFE of (or) HUSBAND of: Hugo Staewen

6 DATE OF BIRTH (month, day, and year): 1122 1859

| 7 AGE Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|
| 67 | 11 | 27 28 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Germany

PARENTS

10 NAME OF FATHER Christain Guethler

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Germany

12 MAIDEN NAME OF MOTHER Elanora Guethler

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Germany

14 Informant: Christian A. Staewen

(Address) 1822 N Port St

15 Filed JAN 20 1927 C. HARRISON JONES, M. D., Registrar

Per K.L.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 January 19, 1927.

17 I HEREBY CERTIFY, That I attended deceased from January 15 1927 to January 19 1927, that I last saw her alive on January 18 1927, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows: Diabetes Mellitus

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis and Clinical Examination

(Signed) Albert Abrahamson, M. D.

1/19 1927 (Address) 2027 E Fifth Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — Date of Burial 1/22 1927

20 UNDERTAKER: Albert L. Hilt Jr. — ADDRESS 1606 N Chester St

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18112

## CERTIFICATE OF DEATH.

E 18112

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. #30 E. Hamilton ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph C. Dunn

(a) RESIDENCE NO. #30 E. Hamilton Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | white | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of M. Philomina Dunn.

6 DATE OF BIRTH (month, day, and year) 12/25/1864

| 7 AGE Years | Months | Days | If LESS than 1 day hrs or min. |
|---|---|---|---|
| 62 | — | 25 | X |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mfg. Co. 045

(b) General nature of industry, business, or establishment in which employed (or employer) Cotton Goods.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Michael Dunn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Welch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Margaret Dunn

(Address) #30 E. Hamilton Ave

15 Filed DEC 20 1927 19 Per HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 7, 1926 to Jan 19, 1927.

that I last saw h alive on Jan 18, 1927

and that death occurred, on the date stated above, at 7:15 A. m.

The CAUSE OF DEATH* was as follows:

Exhaustion + Starvation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma ?

(duration) yrs. mos. ds.

18 What was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clara Dunn, M.D.

1/19, 1927 (Address) 4 W Hamilton Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cath. Cem. DATE OF BURIAL 1/22/27.

20 UNDERTAKER Geo. J. Ruth ADDRESS 1735 Harford

Cor.—12-9-25—A Co.—200 Bks.

E 18113

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 18113

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 316 So. Vincent (St., Ave., or Ward) 19-28

2-FULL NAME Priscilla Farmer

(a) RESIDENCE NO. 316 So. Vincent Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years: about 68 Months: — Days: — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Va

(State or country)

PARENTS

10 NAME OF FATHER: John Jones

11 BIRTHPLACE OF FATHER (city or town): Va

(State or country)

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): Unknown

(State or country)

14 Informant: Elizabeth Jackson (Address) 316 So. Vincent St

15 Filed JAN 20 1927 C. HAMPSON JONES, M. D. Registrar Per KJ

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 18 1927

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry) thereon and from the evidence obtained Inquest and Inquiry (Inquest, Autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

1 Bronchio Pneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Jan 20 1927 Signed Thos. B. Horton, M. D. (Coroner) Address Curtis Bay, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See rule 19 International List)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem Date of Burial: Jan 20th 1927

20 UNDERTAKER: A. E. Jones ADDRESS: 1165 Edmondson Ave

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18114

146

## CERTIFICATE OF DEATH.

E 18114

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Ella Stingate

(a) RESIDENCE NO. 913 N. Regester St. 518 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of Joseph Stingate

6 DATE OF BIRTH (month, day, and year) Dec 30 1894

7 AGE: Years 32 | Months | Days 18 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic Wife

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER John J. Pinto

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Lucy Pedrick

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto. Md.

14 Informant J K Hoerner MD

(Address) Johns Hopkins Hospital.

15 Filed NOV 20 1927 C. HAMPSON JONES, M. D. Registrar Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 17 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1 1926 to Jan. 17 1927,

that I last saw h.. alive on Jan. 17 1927,

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Puerperal metritis

(duration) yrs. 2 mos. 8 ds.

CONTRIBUTORY (Secondary) ① Acute rheumatic arthritis ② Acute rheumatic endocarditis ③ Puerperal hemorrhage ④ Secondary anaemia

(duration) yrs. 2 mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) J K Hoerner, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cem. Date of Burial: Jan. 20th 1927.

20 UNDERTAKER: Lilly-Jeiler. ADDRESS: 4038 Wyth St.

Spec.—1-12-23—M&T—500 Bks.

E 18115

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

161-004

E 18115

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 928 N. Bond ST., 7-13 WARD)

2-FULL NAME Baby Walker -

(a) RESIDENCE NO. 928 N. Bond ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| ♂ | C | S |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1-19-27

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Joseph Walker

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Pearlie Baker

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant
(Address)

15 Filed JAN 20 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-19-1927

17 I HEREBY CERTIFY, That I attended deceased from 1-19, 1927, to 1-19, 1927,

that I last saw h- alive on 1-19, 1927,

and that death occurred, on the date stated above, at 3:41 P.M.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. L. Lewis, M. D.

, 19 (Address) 1502 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL January 19 1927

20 UNDERTAKER Commissioner Health

ADDRESS

For Wm. R. Purcell

Spec.–7-17-26–A Co.–200 Bks.

Dr Buck – 2229 St Paul St

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18116

## CERTIFICATE OF DEATH

100-001

REGISTERED NO. E 18116

1-PLACE OF DEATH

City of BALTIMORE: (No. 2114 Mura St., 8-12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles H Phillips

(a) RESIDENCE NO. 2114 Mura St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 27, 1926

7 AGE: Years 1 Months Days 22 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md

PARENTS

10 NAME OF FATHER Clarence Phillips

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Charlotte Betzel

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Clarence Phillips

(Address) 2114 Mura St

15 Filed JAN 20 1927 by HARRISON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 19 19 27

17 I HEREBY CERTIFY, That I attended deceased from Jan 18, 1927, to Jan 19, 1927, that I last saw h[illegible] alive on Jan 18, 1927, and that death occurred, on the date stated above, at 7:10 m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Leonard C Buck M. D.

, 19 (Address) 2229 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — Date of Burial Jan 21 19 27

20 UNDERTAKER J. M. Cook — ADDRESS 502 E Monument

VERY IMPORTANT. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 13117 — 1-PLACE OF DEATH

71-001 ✓ E 13117 — REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1302 E. Pratt St. 3-5 Ward)

2-FULL NAME Marie Lascione

(a) RESIDENCE NO. 1302 E. Pratt St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Infant.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant.

6 DATE OF BIRTH (month, day, and year): July 31. 1926

7 AGE — Years: — Months: 5. — Days: 14. — If LESS than 1 day, hrs. or min:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Albert Lascione

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Thusa Cusitma

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant (Address): Albert Lascione 1302 E. Pratt St.

15 Filed Jan 20, 1927. C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): January 18 1927

17 I HEREBY CERTIFY, That I attended deceased from January 8, 1927, to January 18, 1927.

that I last saw h[illegible] alive on January 18, 1927

and that death occurred, on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Acute Meningitis (Non Epidemic)

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Unknown.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph L. Volumbino M. D.

January 19 1927 (Address) 14 S. [illegible]

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Jan 21 1927.

UNDERTAKER: Wendell J. Leppel — ADDRESS: 300 S. Colvin

Spec. 6-9-19—H. P. Co.—1000 Bks.

E 18118

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

Aurelia

1002

10 E 18118

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2319 Hunter Pl St. 12-50 WARD)

2-FULL NAME. Amelia Henry

(a) RESIDENCE. NO. 2319 Hunter Pl ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| F | Col | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robt Henry

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| 35 | | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER David Lowman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER (?)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unk

14 Informant (Address) Robt Henry 2319 Hunter Pl

15 Filed N 20 1927, 19 HARRISON JONES, M. D., Registrar. by RH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct, 1926, to Jan 18, 1927

that I last saw her alive on Jan 13, 1927

and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Dilatation of heart

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Physical signs

(Signed) A. W. Peterson, M. D.

19 (Address) 205 N Glas St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Mt Auburn Cem. | 1/21/27 |

| 20 UNDERTAKER | ADDRESS |
|---|---|
| Mrs. A. C. Elliott | 1725 Ashland |

Spec.—1-12-23—M&T—500 Blks.

E 18119

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 18119

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 611 West Lan Rasburg ST. WARD)

2-FULL NAME Catherine M. Tinnin

(a) RESIDENCE NO. 611 West Lan Rasburg ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE: Lady white

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harry J Tinnin

6 DATE OF BIRTH (month, day, and year): June 30 1898

7 AGE: Years 28 Months 6 Days 18 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: William Rowster

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Mary Clewell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Mr Harvey Tinnin

(Address) 611 West Lan Rasburg

15 Filed JAN 20 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 28, 1926, to January 18th, 1927, that I last saw her alive on January 18, 1927, and that death occurred, on the date stated above, at 12 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary): Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? N Date of

Was there an autopsy? No.

What test confirmed diagnosis? Tubercular Bacilli in sputum

(Signed) Wm Conrad Bode, M. D.

, 19 (Address) 1900 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross

DATE OF BURIAL: Jan. 21 1927

20 UNDERTAKER: Chas L Sterns

ADDRESS: [illegible]

Spec.—1-12-23—M&T—500 Bks.

E 18120 HEALTH DEPARTMENT—CITY OF BALTIMORE E 18120

# CERTIFICATE OF DEATH.

101-0

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1240 E. Monument ST. 10-14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Williams

(a) RESIDENCE NO. 1240 E. Monument ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | Col. | Widowed |

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of John Williams

6 DATE OF BIRTH (month, day, and year) — — 1870

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| 57 | 56 | ? | ? | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ? (State or country) South Carolina

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) [illegible]

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) [illegible] (State or country) [illegible]

14 Informant Susie Johnson (Address) 1240 N Monument St

15 Filed JAN 20 1927 C. HAMPSON JONES, M. D. Registrar

Per [illegible]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 15, 1927, to Jan. 19, 1927, that I last saw h— alive on Jan. 19, 1927, and that death occurred, on the date stated above, at 12:40 P.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exa.

(Signed) W. A. Bailey, M. D.

, 19 (Address) 1520 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary Cemt. DATE OF BURIAL 1/20/27

20 UNDERTAKER Mrs. R. G. Elliott ADDRESS 1725 Ashland Av

Cor.—12-9-25—A Co.—200 Bks.

(J. Wesley Smith) ✓ 101-081

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18121

E 18121

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 25-78 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wesley Smith

(a) RESIDENCE NO. 902 Baltimore St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | white | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 14-1879

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 47 | 8 | 4 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Laundering

(c) Name of employer Erlangher

9 BIRTHPLACE (city or town) Balto

(State or country)

PARENTS

10 NAME OF FATHER James Smith

11 BIRTHPLACE OF FATHER (city or town) Balto Co

(State or country)

12 MAIDEN NAME OF MOTHER E. Daniels

13 BIRTHPLACE OF MOTHER (city or town) Balto Co

(State or country)

14 Informant C. D. Francis

(Address) Cockeysville Balto Co

Jan 18 1927 C. HAMPSON JONES, M. D.

Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) 1 wk. yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

(Coroner)

Jan 18, 1927 (Address) 1059 Arnold

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. 1 day mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery Date of Burial Jan 21 1927

20 UNDERTAKER George L. Schmidt & Co ADDRESS Eutaw & Fayette Sts

Spec.—8-24-14—M. & T.—2000 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18122 E 18122

## CERTIFICATE OF DEATH.

179

REGISTERED NO. C 18-29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1115 N. Lombard St.; WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward F. Hisky,

(Residence in Baltimore: No. 1115 N. Lombard St. St.; yrs., mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE. White.

5-~~SINGLE, MARRIED,~~ WIDOWED, ~~OR DIVORCED,~~ (Write the word.) Widower

6-DATE OF BIRTH. Oct. 23, 1842 (Month) (Day) (Year)

7-AGE. 84 yrs. 2 mos. 27 ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Moulder
(b) General nature of industry, business, or establishment in which employed (or employer). Moulding

9-BIRTHPLACE, (State or Country). Balto, Md.

PARENTS.

10-NAME OF FATHER. Joseph Hisky,

11-BIRTHPLACE OF FATHER (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER. Mary Savier,

13-BIRTHPLACE OF MOTHER (State or Country). Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. H. Knott,

(Address) 1115 N. Lombard St.

15- C. HAMPSON JONES, M. D.

20 1927 191... Registrar

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Jan. 19, 1927 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1926, to Jan. 19, 1927, that I saw him alive on Jan. 18 1927, and that death occurred, on the date stated above, at 1:30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Int. Nephritis

(Duration) ...yrs. 9 mos. ...ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

(Duration) ...yrs. 9 mos. ...ds.

(Signed) Chas. V. Watkins, M. D.

1/20, 1927. (Address) 1115 N. Lombard St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Greenmount

DATE OF BURIAL. Jan. 22, 1927

20-UNDERTAKER John Wells

ADDRESS 1200 N. Lombard

Spec.—1-12-23—M&T—500 Blks.

E 18123

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 E 18123

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1213 W Lexington ST. 18-76 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Claudius Merdett Wright

(a) RESIDENCE NO. 1213 W. Lexington ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. 5 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lilly Engle Wright

6 DATE OF BIRTH (month, day, and year) July 21 1889

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs or ... min. |
|---|---|---|---|---|
| | 37 | 5 | 29 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Collector

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James Pilghman Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Caroline Co Md

12 MAIDEN NAME OF MOTHER Mary Ella McGill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant J. Pilghman Wright

(Address) 1213 W Lexington St

15 Filed 0 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1927, to Jan 19, 1927, that I last saw h alive on Jan 19, 1927 and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

1 Pulmonary Tuberculosis

(duration) Indefinite yrs. mos ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. E. Campbell M. D.

1927 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Spring Hill Cemetery Eastern Ave | Jan 21 1927 |

20 UNDERTAKER John H. Denny ADDRESS 715 Light St

Spec.–7-17-26—A Co.—200 Bks.

Dr Binns ✓ 375 Fulton St

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-00

E-18124

## CERTIFICATE OF DEATH

E-18124

1-PLACE OF DEATH

REGISTERED NO._____

City of BALTIMORE: (No. 35 S Stricker St. (9-27) Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Emestine

(a) RESIDENCE NO. 35 S. Stricker St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W. | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Emestine

6 DATE OF BIRTH (month, day, and year) March 17. 1885

| 7 AGE | Years | Months | Days | IF LESS than 1 day ... hrs. or ... min.. |
|---|---|---|---|---|
| | 41 | 10 | 1 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer) 059

(c) Name of employer Mr Long

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER David Emestine

11 BIRTHPLACE OF FATHER (City or town) Ga

(State or country)

12 MAIDEN NAME OF MOTHER Ella Bradbach

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Emma Emestine

(Address) 35 S. Stricker St

15 Filed 0 1927 C. HAMPSON JONES, M. D. Registrar

Per DKW

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 11, 1927, to Jan 18, 1927.

That I last saw him alive on Jan 18, 1927,

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

6d (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Anthony V. Bykowski M. D.

, 19 (Address) 37 S. Stricker St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| London Park | Jan 23 1927 |
| 20 UNDERTAKER | ADDRESS |
| H. M. Cook | 502 E Monument |

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18125

## CERTIFICATE OF DEATH.

E 18125

REGISTERED NO. 49

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 76-37 St., Ward)

2-FULL NAME Edward Pindell

(a) RESIDENCE NO. _____ St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widowed |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1861

| 7 AGE | Years | Months | Days | IF LESS than 1 day....hrs. or....min. |
|---|---|---|---|---|
| | 66 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gardener

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?

(State or country)

14 Informant

(Address) Records

1927 C. HAMPSON JONES M. D. Registrar

1927 0968 ARR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 18 1927

17 I HEREBY CERTIFY, That I attended deceased from December 24, 1926, to January 18, 1927, that I last saw him alive on January 17, 1927 and that death occurred, on the date stated above, at 5-20 P m.

The CAUSE OF DEATH* was as follows:

Generalized abdominal carcinomatosis (Organ not known)

(duration) ? yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? general & laboratory

(Signed) C. Hampson Jones M. D.

Jan. 18 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 1/21/27, 19

20 UNDERTAKER ADDRESS

H E Stiles 231 Mc Culloh

Spec.—12-9-25—A Co.—200 Blks.

E 18126

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18126

## CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH ALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. 26-29 Street (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Gutchen

(a) RESIDENCE NO. 222 N. 4th or 435 South Chester Street

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widowed |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1863

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 63 72 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER William Gutchen

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Dora —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant

(Address) BALTIMORE CITY HOSPITALS Records

C. HAMPSON JONES, M. D.

15 Filed ..... 19 ..... Registrar

0 1927 6969

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 18 1927

17

I HEREBY CERTIFY, That I attended deceased from December 3, 1926, to January 18, 1927, that I last saw him alive on January 15, 1927, and that denth occurred, on the date stated above, at 9A m.

The CAUSE OF DEATH* was as follows:

Emphysema

Pleurisy c Effusion (etiology not proven)

Chronic Myocarditis

(duration) ....yrs. ?mos. ....ds.

CONTRIBUTORY Terminal bronchopneumonia

(Secondary)

(duration) ....yrs. ....mos. 4 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? General & Laboratory

(Signed) R. Hooper Smith, M. D.

Jan 20 1927 Address BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date

Interred and buried Jan 22 1927

Mary Hemphelly Mt Carmel

20 UNDERTAKER ADDRESS

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18127

74-801

E 18127

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 6-9 St. (Ward)

2-FULL NAME Edward Brown

(a) RESIDENCE NO. 406 N. Conn St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1880

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 47 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Porter

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER John M. Brown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Anna M—

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Indiana

14 Informant

(Address) Records

JOHNS HOPKINS HOSPITAL

JAN 20 1927

C. HANSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 19 1927

17 I HEREBY CERTIFY, That I attended deceased from November 4, 1926, to January 19, 1927, that I last saw him alive on January 16, 1927, and that death occurred, on the date stated above, at 8 30 A m.

The CAUSE OF DEATH* was as follows:

Hypertension
Arterial Sclerosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Haemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? General & Laboratory

(Signed) R. Hodges Smith, M. D.

Jan 20 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Grove Date of Burial Jan 24, 1927

20 UNDERTAKER: Chris Johnson ADDRESS 416 N Caroline

JOHNS HOPKINS HOSPITAL

JAN 20 1927

Commissioner of Health

Spec.—1-12-23—M&T—500 Blks.

E 18128

# HEALTH DEPARTMENT—CITY OF BALTIMORE

91-502

E 18128

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 434 E. Biddle ST. 17-24 WARD)

2-FULL NAME Edward T. Sheil

(a) RESIDENCE NO. 434 E. Biddle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? 78 yrs. -- mos. -- ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widower |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bridget Horrigan

6 DATE OF BIRTH (month, day, and year) Nov. 4, 1838

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs or ....min. |
|---|---|---|---|---|
| | 88 | 2 | 15 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Printer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Dublin
(State or country) Ireland

PARENTS

10 NAME OF FATHER Michael Sheil

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Annie Watson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Miss Mary T. Sheil
(Address) 434 E. Biddle Street

Filed 1 20 1927 C. HAMPSON JONES, M. D. Registrar
Per RKG

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1. 19. 1927

17

I HEREBY CERTIFY, That I attended deceased from July 15th, 1926, to January 19th, 1927, that I last saw h[illegible] alive on January 19th, 1927, and that death occurred, on the date stated above, at 6.50 A m.

The CAUSE OF DEATH* was as follows:

Senility p Heart Exhaustion

(duration) yrs. 7 months ds.

CONTRIBUTORY (Secondary) Artio Sclerosis, 20 years.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Symptoms.

(Signed) Wilmer Brinton, M. D.

, 19 (Address) S. W. Cor. Caerat & Greitzer Sts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 1/21 1927

20 UNDERTAKER Henry W. Dears Inc.

ADDRESS 805 N. Calvert

Spec.—1-10-21—M&T—1500 Bks.

E 18129

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18129

## CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2302 Avalon Ave ST. 13-59 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillie M. Frey

(a) RESIDENCE NO. 2302 Avalon Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W.

5 ~~Single~~, Married, ~~Widowed, or Divorced~~, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Frey

6 DATE OF BIRTH (month, day, and year) Feb 18 1867

7 AGE

| Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|
| 59 | 11 | 1 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John C Ferguson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Elizabeth Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant (Address) Chas Frey 2302 Avalon Ave

15 Filed JAN 1927, 19 C. HAMPSON JONES, M.D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 19th 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 27 1926 to Jan 19 1927.

that I last saw h alive on Jan 18 1927

and that death occurred, on the date stated above, at 3 40 A.M. P.M.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Myocarditis

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Sign

(Signed) Nathaniel Garber M. D.

(Address) 21 01 Gwynn Oak Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery DATE OF BURIAL Jan 21 1927

20 UNDERTAKER Putnam & Gore ADDRESS 1725 N. Eutaw

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E-18130

31 E 18130

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 3119 Foster Ave. St. 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Madeline Menke.

(a) RESIDENCE NO. 3119 Foster Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 26-1900

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 26 | 2 | 21 | 22 |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Inspector do

(b) General nature of industry, business, or establishment in which employed (or employer) Crown Cork & Seal Co

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER August Menke.

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Elizabeth Wolf.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germ

14 Informant Emma Vasold.

(Address) 3119 Foster Ave.

15 C. HAMPSON JONES, M. D.

0 1927 Per ACK Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Jan. 17-1927

17 I HEREBY CERTIFY, That I attended deceased from June, 19 24 to Jan 17, 19 27

that I last saw h alive on Jan 17, 19 27

and that death occurred, on the date stated above, at 9.20 P. m.

The CAUSE OF DEATH* was as follows

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

1/18. 1927 (Address) 2939 W. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. Date of Burial Jan. 20 1927

20 UNDERTAKER Lilly & Zeiler ADDRESS 403 S. Wolfe St.

Spec.—1-12-23—MET—2m—Bks.

1927 E 18131

# HEALTH DEPARTMENT—CITY OF BALTIMORE

1927 E 18131

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ) ST., 7-9 (WARD)

2-FULL NAME Forcie Massey

(a) RESIDENCE NO. Sutherland Rd ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | Col | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary

6 DATE OF BIRTH (month, day, and year) 1899

| 7 AGE Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|
| 28 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va (State or country)

10 NAME OF FATHER Will Massey

11 BIRTHPLACE OF FATHER (city or town) Va (State or country)

12 MAIDEN NAME OF MOTHER Katherine Tignley

13 BIRTHPLACE OF MOTHER (city or town) Va (State or country)

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 1927 Per C. HAMPSON JONES, M. D. 19 RKN Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 7, 1927, to Jan. 20, 1927

that I last saw h alive on Jan 20, 1927

and that death occurred, on the date stated above, at 4 30 p m.

The CAUSE OF DEATH* was as follows:

Typhoid fever. Perforated ulcer of intestine. Pneumonia, Peritonitis & coli

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan 11 '27

Was there an autopsy? Yes

What test confirmed diagnosis? Blood culture + W.R.

(Signed) Winfield M Jerson M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Leesburg Va | 7/20/27 |
| 20 UNDERTAKER | ADDRESS |
| Joseph Ahrens | 221 Bway |

Spec.—7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18132

## CERTIFICATE OF DEATH

101-001

REGISTERED NO. 27-57

1-PLACE OF DEATH

City of BALTIMORE: (No. 103 Avondale Ave St.) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma J. Leister

(a) RESIDENCE NO. 103 Avondale Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. — mos. — ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, ~~Married~~, ~~Widowed~~, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): March 10 1860

7 AGE: Years 66 Months 10 Days 9 IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Carroll Co Md

(State or country)

PARENTS

10 NAME OF FATHER Daniel A Leister

11 BIRTHPLACE OF FATHER (City or town) (State or country) Carroll Co Md

12 MAIDEN NAME OF MOTHER Mary C. Shanahan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carroll Co Md

14 Informant Sister Emma J. Leister

(Address) 103 Avondale Ave

15 Filed JAN 20 1927 C. HAMPSON JONES, M. D. Registrar

Per ARA

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JAN 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 14, 1927, to Jan 19, 1927.

that I last saw h[er] alive on Jan 19, 1927.

and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted —

If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Charles J. Bello, M. D.

19 (Address) 5242 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — Date of Burial JAN 22 1927

20 UNDERTAKER: Geo W Little — ADDRESS

E 18133 HEALTH DEPARTMENT—CITY OF BALTIMORE E 18133

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. University Hosp. ST. 4-30 WARD) REGISTERED NO. C 174

2-FULL NAME Frank S. Bell

(Residence in Baltimore: No. 505 W. Lombard St.: yrs., mos. 10 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

| 3-SEX. | 4-COLOR OR RACE. | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) |
|---|---|---|
| Male | White | Married |

6-DATE OF BIRTH, Sept. 20, 1886
(Month) (Day) (Year)

| 7-AGE, | If LESS than 1 day, |
|---|---|
| 40 yrs. 3 mos. 30 ds. | ....hrs. or....min.? |

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Soldier U.S.A.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Charles Bell

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER Margaret Patterson

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rosa S. Bell

(Address) 43 Wheeler ave

15-

Filed ..... 1927 C. HAMPSON JONES, M. D.

Per ..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 19, 1927.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns 2nd & 3rd degree face & hands, septic burns (external) Bronchopneumonia

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Active Tuberculosis

(Duration) ... yrs. ... mos. ... ds.

(Signed) ..... M. D.
(Coroner.)

....., 1927 (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence Camp Meade Md

| 19-PLACE OF BURIAL OR REMOVAL, | DATE OF BURIAL, |
|---|---|
| National Cem | Jan 22, 1927 |

| 20-UNDERTAKER | ADDRESS |
|---|---|
| Wm Mus. John N. Teufel & Son | 501 W Fayette St |

Spec.—1-12-23—M&T—500 Bks.

E 18134

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18134

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3817 Liberty Heights Ave. ST. 15-67 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johanna Frank.

(a) RESIDENCE NO. 3817 Liberty Heights Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? 33 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick Frank.

6 DATE OF BIRTH (month, day, and year) May 22nd. 1856

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 70 | 8 | 27 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Jonas Schloss

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER -------- Baum.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mr. Jonas Frank (Address) 2116 Brookfield Ave.

15 Filed JAN 20 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany. 19th. 1927.

17

I HEREBY CERTIFY, That I attended deceased from Jan 16, 1927. to Jan 19, 1927. that I last saw h alive on Jan 18, 1927. and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Rt side Hemiplegia

(duration) yrs. mos. 36 hrs ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Harold Kahn, M. D.

, 19 (Address) 2027 West Pratt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Hebrew Cem.

DATE OF BURIAL 1/21/ 1927

20 UNDERTAKER David Londheim

ADDRESS 116 20 W. Mt. Royal Ave.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

E 18135

## CERTIFICATE OF DEATH.

E 18135

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 522 N. Carrollton Ave Ward) 18-26

2-FULL NAME: Joseph Hennessy

(a) RESIDENCE NO. 522 N. Carrollton Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | white | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) uncertain

| 7 AGE | Years | Months | Days | If less than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 69 | - | - | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Helper 186

(b) General nature of industry, business, or establishment in which employed (or employer) Construction Dept

(c) Name of employer C. & P. Telephone Co.

9 BIRTHPLACE (city or town) Washington

(State or country) D. C.

PARENTS

10 NAME OF FATHER Timothy Hennessy

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Jones

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Miss Nellie Griffin

(Address) 522 N. Carrollton ave

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

P—

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 Jan 18

17 I HEREBY CERTIFY, That I attended deceased from Jan 2 1927 to Jan 18 1927

that I last saw h— alive on Jan 18 1927

and that death occurred, on the date stated above, at 11-45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) Jno R. L. Campbell, M. D.

Jan 20, 1927 (Address) 1604 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — Date of Burial: Jan 21 1927

20 UNDERTAKER: Chas. G. Black — ADDRESS: 742 W. North ave

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18136

## CERTIFICATE OF DEATH.

49 E 18136

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 416 N. Broadway ST. 6-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Joseph Cadwalader

(a) RESIDENCE NO. 416 N. Broadway ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widowed |

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Amelia V. Cadwalader

6 DATE OF BIRTH (month, day, and year) Jan. 2, 1867.

| 7 AGE | Years | Months | Days | If LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 60 | — | 16 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

009

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Arthur Cadwalader

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Margaret King

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Co., Md.

14 Informant Addie Weustlof (Address) 416 N. Broadway.

15 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 18, 1927.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 17, 1926, to Jan. 18, 1927, that I last saw him alive on Jan. 18, 1927, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate.

(duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No especial test.

(Signed) B Herman, M. D.

1-18-1927. (Address) 1012 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL Jan 21 1927

20 UNDERTAKER Chas. G. Black — ADDRESS 742 W. North ave

E 18137

# HEALTH DEPARTMENT--CITY OF BALTIMORE

## CERTIFICATE OF DEATH

× 90

E 18137

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 100 E 23d St ST. 12-50 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

2 FULL NAME Belle M Crane

(Residence in Baltimore: No. Chestertown Md St.: yrs. 2 mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): widowed

6 DATE OF BIRTH: Mch 27, 1857 (Month) (Day) (Year)

7 AGE: 69 yrs. 9 mos. 23 ds. If LESS than 1 day, ..... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Caroline Co Md.

PARENTS

10 NAME OF FATHER: Marcie Fountaine

11 BIRTHPLACE OF FATHER (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Louise Thawley

13 BIRTHPLACE OF MOTHER (State or country): Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emma L Ely

(Address) 2813 Mosher St

15. 1927 Feb ..... 191 C. HAMPSON JONES, M. D. REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jan 20, 1927 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased fr
Nov 20, 1926 to Jan 20 19
that I saw h alive on Jan 20 19
and that death occurred, on the date stated above, at 6.30 p m.
The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(Duration) 2 yrs. — mos. — ds

Contributory (SECONDARY) Coronary Thrombosis

(Duration) yrs. mos. 1 ds.

(Signed) Hardey S Beach M. D.

Jan 20 1927 (Address) 100 E. 23d St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. 7 ds. In the State yrs. mos. 7 ds.

Where was disease contracted, if not at place of death?

Former or usual residence Chestertown Md

19 PLACE OF BURIAL OR REMOVAL: Chestertown Md — DATE OF BURIAL: Jan 21 1927

20 UNDERTAKER: Stewart Mowells — ADDRESS: 108 W Mt St

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18138

## CERTIFICATE OF DEATH.

E 18138

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1810 Harlem Av ST. 16-22 WARD) 129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara Kroneberger

(a) RESIDENCE NO. 1810 Harlem Av ST., WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. 4 mos. 4 ds. How long in U. S., if of foreign birth? 46 yrs. 4 mos. 4 ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Wm. H. Kroneberger

6 DATE OF BIRTH (month, day, and year) Sept-16-1880

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs. or ....min. |
|---|---|---|---|---|
| | 46 | 4 | 4 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) Household

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland.

PARENTS

10 NAME OF FATHER Louis Knepper

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Maylynd

12 MAIDEN NAME OF MOTHER Bertha ???

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant W. H. Kroneberger (husband)
(Address) 1810 Harlem Ave City

Filed JAN 20 1927 19 C. HAMPSON JONES, M. D. Registrar

Per ACK

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 19 19 27

17

I HEREBY CERTIFY, That I attended deceased from Sept 27 19 26, to Jan 19 19 27.

that I last saw h... alive on Jan 18 19 27,

and that death occurred, on the date stated above, at 3:45 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Pneumonia

Contributory Chronic Colitis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) a Chronic Colitis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Symptoms

(Signed) Edward Krause, M. D.

Jan 19 19 27 (Address) 1810 Harlem Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Loudon Park Cemetery | Jan-21-1927 |

| 20 UNDERTAKER | ADDRESS |
|---|---|
| Stewart & Mercer Co | Balto Md. |

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18139

## CERTIFICATE OF DEATH.

31 E 18139

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1116 Myrtle ST., 17-23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Dolta Dunston

(a) RESIDENCE NO. 1116 Myrtle ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lillian Lewis

6 DATE OF BIRTH (month, day, and year): Sept. 17. 1876

7 AGE: Years 50 Months 4 Days 3 If LESS than 1 day, ..... hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Porter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Pullman Car Service

9 BIRTHPLACE (city or town) (State or country): Franklinton N. C.

PARENTS

10 NAME OF FATHER: Benjamin Dunston

11 BIRTHPLACE OF FATHER (city or town) (State or country): Franklinton N. C.

12 MAIDEN NAME OF MOTHER: Rachel Blackwell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. C.

14 Informant (Address): Charles D Dunston 1116 Myrtle ave.

15 Filed Jan 20 1927 C. HAMPSON JONES, Registrar. Per ECR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 20 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1926, to Jan 20, 1927, that I last saw h- alive on Jan 19, 1927 and that death occurred, on the date stated above, at 6.30 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. + mos. ds.

CONTRIBUTORY (Secondary): None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? North Carolina?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical -

(Signed) W H Wright M. D.

(Address) 1209 Presbyterian St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Phila. Pa.

DATE OF BURIAL: 1/22/ 1927

20 UNDERTAKER: Mrs. Geo. H. Holland

ADDRESS: 160 Druid Hill ave

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18140

## CERTIFICATE OF DEATH.

90 E 18140

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 2800 Elisnor ave ST., 15-61 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Aaron Kwitz

(a) RESIDENCE NO. 2800 Elisnor ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. — mos. — ds. How long in U. S., if of foreign birth? 42 yrs. — mos. — ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Dinah

6 DATE OF BIRTH (month, day, and year): 1852

7 AGE — Years: 75 — Months: — — Days: — — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Lithuania

PARENTS

10 NAME OF FATHER: Abraham Kwitz

11 BIRTHPLACE OF FATHER (City or town) (State or country): Lithuania

12 MAIDEN NAME OF MOTHER: Jennie U K. 1/20, 19 27

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Lithuania

14 Informant: D M W Hanson

(Address): 1706 Eutaw Place

Filed 1927 T. HARRISON JONES, M. D.

Per K K Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 20 19 27

17 I HEREBY CERTIFY, That I attended deceased from Jan. 18 —, 19 27, to Jan - 20 - 1927.

that I last saw him alive on Jan - 20 —, 1927

and that death occurred, on the date stated above, at 1 30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Herman Seidel, M. D.

(Address) 2404 Eutaw pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Hmng Rm

DATE OF BURIAL: 1/21 19 27

20 UNDERTAKER: Sol Linnon & Bro

ADDRESS 1121 E Balto st

Spec.—1-12-23—M&T—500 Blks.

18141

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 18141

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1615 moreland av ST., 15-68 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Wolf Cohen

(a) RESIDENCE No. 1615 moreland av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of —

7 DATE OF BIRTH (month, day, and year) Jan. 1912

8 AGE: Years 15 | Months | Days | If LESS than 1 day, hrs. or min.

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

10 BIRTHPLACE (city or town) (State or country): Balto., Md.

11 NAME OF FATHER: Isaac Cohen

12 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

13 MAIDEN NAME OF MOTHER: Sarah Lankoff

14 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

PARENTS

15 Informant: Isaac Cohen

(Address): 1615 Moreland Ave

16 Filed 1927, 19 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 21st 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 21st, 1927, to Jan. 21st, 1927, that I last saw h in alive on Jan. 21, 1927 and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Chronic mitral Insufficiency

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R. A. Nicholson, M. D.

Jan 21 1927 (Address) 2230 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pikesville Hebrew Cem

DATE OF BURIAL: 1-21- 1927

20 UNDERTAKER: Jos. Krug

ADDRESS: 1419 E. Balto.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18142

## CERTIFICATE OF DEATH.

100-001 E 18142

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 7-13 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Taylor

(a) RESIDENCE NO. 1802 E. Madison St Baltimore MD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col-

5 Single, Married, Widowed, or Divorced, (write the word)

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 12 1926

7 AGE

| Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|
| 8 days. | 2 | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER ——

11 BIRTHPLACE OF FATHER (city or town) (State or country) ——

12 MAIDEN NAME OF MOTHER Ophelia Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Parents

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 2 1 1927 C. HAMPSON JONES, M. D. Registrar

Per ——

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 24, 1926, to Jan 18, 1927, that I last saw h alive on Jan. 18, 1927 and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia, broncho

(duration) yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary) Prematurity Life

(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Thomas W. Cornwall, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL 19

20 UNDERTAKER: JOHNS HOPKINS HOSPITAL — ADDRESS

Spec.–7-17-26—A Co.—200 Bks.

E 18143

# HEALTH DEPARTMENT—CITY OF BALTIMORE

159-002

E 18143

## CERTIFICATE OF DEATH

REGISTERED NO. _____

1-PLACE OF DEATH

City of BALTIMORE: (No. 1517 Eastern ave St. 3-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cecilia Gogul

(a) RESIDENCE NO. 1517 Eastern ave St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U. S. If of foreign birth? _____ yrs. _____ mos. _____ ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 16 1927

7 AGE — Years — Months 4 Days IF LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Frank Gogul

11 BIRTHPLACE OF FATHER (City or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Czeslawa Mislak

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant Mr Frank Gogul
(Address) 1517 Eastern ave

Filed 1927 19

21 1927 C. HA[illegible] JONES, M. D.

Per _____

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 20 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Jan 16 1927 to Jan 20 1927

that I last saw h[illegible] alive on Jan 20 1927

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Congenital Heart Trouble

(duration) _____ yrs. _____ mos. 4 ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm J Kupchick M. D.

1927 (Address) 809 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Holy Rosary Cem | Jan 21 1927 |
| 20 UNDERTAKER | ADDRESS |
| John M Weber | 1803 Bank st |

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

100-001

E 18144 — REGISTERED NO. E 18144

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) 317 N. Fulton Ave ST., 1927 WARD)

2-FULL NAME Margaret Hamer

(a) RESIDENCE NO. 317 N Fulton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 18. 1843

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 83 | 4 | 2 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Robert Crime

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Sarah Atkinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mrs Sarah E. Windsor

(Address) 317 N. Fulton Ave

Filed 2 1 1927, 19 C. HAMPSON JONES, M. D. Registrar

By RJK.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1927, to Jan 20, 1927, that I last saw h alive on Jan 19, 1927, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Debilitated a pneumonia

Duration 5 days

CONTRIBUTORY (Secondary) Gen. arteriosclerosis

Duration 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

1/27, 1927 (Signed) Bernard Turnbull, M. D.

(Address) 717 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL Jan 22 1927

20 UNDERTAKER George J Smith ADDRESS Hillen & Eutaw Sts

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18145

## CERTIFICATE OF DEATH

74-001 E 18145

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 2402 Eagle St., 9-46 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daisy Anna Schaller

(a) RESIDENCE NO. 2402 Eagle St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Schaller 573

6 DATE OF BIRTH (month, day, and year) July 20-1873

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..hrs. or ..min.. |
|---|---|---|---|---|
| | 53 | 4 | 29 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 27

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto

PARENTS

10 NAME OF FATHER John Gardner

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Catherine Gardner

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Louis Schaller

(Address) 2402 Eagle St.

15 Filed JAN 21 1927 C. HAMPSON JONES, M. D. Registrar

By RM

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 5, 1926, to Jany 19, 1927, that I last saw her alive on Jany 18, 1927, and that death occurred, on the date stated above, at 2 hrs m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. 4 mos. 15 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted ~

If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Fritz J Kimzey, M. D.

1/20, 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — Date of Burial Jan 21 1927

20 UNDERTAKER W. M. Cook — ADDRESS 2402 Eagle St

Spec.-7-17-26—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18146 ✓ 129 E 18146

## CERTIFICATE OF DEATH

REGISTERED NO. 25-72

1-PLACE OF DEATH

City of BALTIMORE: (No.) St Agnes Hospital St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Ingham

(a) RESIDENCE NO. Catonsville, Md St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE: 34 Years | Months | Days | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lumber do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Main

9 BIRTHPLACE (city or town)

(State or country)

PARENTS

10 NAME OF FATHER A. Ingham

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Do not know

12 MAIDEN NAME OF MOTHER " " "

13 BIRTHPLACE OF MOTHER (city or town) " "

(State or country)

14 Informant: Walter Ingham

(Address) Catonsville Md

15 Filed JAN 21 1927 19 C. HARRY JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-18-27 19

17 I HEREBY CERTIFY, That I attended deceased from 1-13, 1927, to 1-18, 1927

that I last saw him alive on 1-18, 1927

and that death occurred, on the date stated above, at 12 2 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Diffuse Nephritis

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Catonsville Md.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical.

(Signed) A. J. Knapp, M. D.

1-18, 1927 (Address) St. Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Vault — Date of Burial: 1/21 19 27

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E Fayette

Cor.—12-9-25—A Co.—200 Bks.

E 18147

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

188-002

2-4

REGISTERED No. E 18147

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. ____ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME J.F. Wm. Tripp

(a) RESIDENCE NO. 2025 E. Pratt St. ____ Ward ____

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | single |

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ))))

6 DATE OF BIRTH (month, day, and year) Jan 10/1906

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 21 | 0 | 8 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer) Md. School for

(c) Name of employer Blind

9 BIRTHPLACE (city or town) ____

(State or country) Balto: Md

PARENTS

10 NAME OF FATHER Henry Tripp

11 BIRTHPLACE OF FATHER (city or town) ____

(State or country) Md

12 MAIDEN NAME OF MOTHER Margaret W. Plaehner

13 BIRTHPLACE OF MOTHER (city or town) ____

(State or country) Md

14 Informant H. Herman Tripp

(Address) 14 N Kenwood Ave

JAN 21 1927 C. HARRISON JONES, M. D. City Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 13/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquory (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intracrainal Hemorrhage-Frac. Skull
Struck by Street Car., at Pratt & Collington Ave (occ)

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY ____
(Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) J. J. Hollins, M. D.
(Coroner)

1/21/27 (Address) 500 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ....mos., ....ds. In the State ....yrs., ....mos., ....ds.

Where was disease contracted, if not at place of death? ____

Former or usual residence ____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem — Date of Burial Jan 21 1927

20 UNDERTAKER Philip Herwig — ADDRESS 2016 Orleans

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18148

## CERTIFICATE OF DEATH.

24-001

E 18148

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 1 Hicornico & Ba 21-29 St., _____ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George H. Haynes

(a) RESIDENCE NO. 1057 Malden St St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widower |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 31st 1849

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 77 | 11 | 19 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Night Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer H B Davis Paint Co

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER Wm H. Haynes

11 BIRTHPLACE OF FATHER (city or town)

(State or country) England

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Walter Haynes

(Address) 2464 Fulton St

15 Filed JAN 21 1926 HAMILTON JONES, M. D. Registrar

By _____

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/19 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) 1 yrs. ____ mos. ____ ds.

CONTRIBUTORY —

(Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) Thos B. Horton M. D.

(Coroner)

Jan 19th 1927 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| London Park | 1/21 1927 |

20 UNDERTAKER Carlis Herring ADDRESS 2016 Orleans

Spec.—1-12 23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18149

## CERTIFICATE OF DEATH.

101-001 E 18149

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Josephs Hospital ST., 9-17 WARD

2-FULL NAME Frederick A. Ewers

(a) RESIDENCE NO. Fullerton Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of or) WIFE of: Margaret O'Brien Ewers

6b DATE OF BIRTH (month, day, and year): Jan 1st 1869

7 AGE: Years 58 Months — Days 18 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer): Furniture

(c) Name of employer: Connelly & Constance

9 BIRTHPLACE (city or town) (State or country): Baltimore Md. Maryland

10 NAME OF FATHER: August Ewers

11 BIRTHPLACE OF FATHER (city or town): Unknown

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): Unknown

(State or country): Unknown

14 Informant: Margaret M. Ewers

(Address): Fullerton Md.

15 Filed JAN 21 1927, 19 C. HARPER JONES, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 17 .1927. to Jan 19 .1927.

that I last saw him alive on Jan 19 .1927

and that death occurred, on the date stated above, at 10.30 P m.

The CAUSE OF DEATH* was as follows:

Central Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary): Paralytic Ileus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Frank R. Di Pauls, M. D.

, 19 (Address) St. Joseph's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery

DATE OF BURIAL: Jan 22 27

20 UNDERTAKER: Fred'k Lassahn & Son

ADDRESS: Fullerton

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

18150

## CERTIFICATE OF DEATH.

E 18150

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1076 E. Hamilton ave. ST., 27 Hamilton (WARD)

2-FULL NAME Mildred A. Schult

(a) RESIDENCE No. 1076 E. Hamilton ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sidney Schult

6 DATE OF BIRTH (month, day, and year) April 25th 1900

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 26 | 8 | 26 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Co.
(State or country) Maryland

PARENTS

10 NAME OF FATHER Seth H. Nichols

11 BIRTHPLACE OF FATHER (city or town) Fredk Co.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Lula Christopher

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co.
(State or country) Maryland

14 Informant Lula Nichols
(Address) 1076 E. Hamilton ave. Hamilton

15 Filed ..... 19..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 21 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1925 to Jan 21 1927.

that I last saw her alive on Jan 20 1927.

and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Aortic Insufficiency

(duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Asthenia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) Albert H. Levy M. D.

19 (Address) 6 W Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Jan. 24 1927

20 UNDERTAKER: Fredk Lauchheimer Son — ADDRESS: Baltimore

HAMPSON JONES, M. D. Registrar

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18151

## CERTIFICATE OF DEATH.

57

E 18151

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3900 Greenmount ST., 17 WARD) Guilford 17-49

2-FULL NAME J. Otto Malchow

(a) RESIDENCE NO. 3900 Greenmount ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? 47 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word): Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Meta Malchow

DATE OF BIRTH (month, day, and year): July 12 1846

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| 80 | | 6. | 8 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

BIRTHPLACE (city or town) (State or country): Germany.

10 NAME OF FATHER J. Otto Malchow.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Kulenkamp. Germany.

Informant: Grace Malchow

(Address) 3900 Greenmount Ave

Filed JAN 21 1927 C. HAMPSON JONES, M. D. Registrar

By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 20 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 16., 1926, to Jan 20, 1927, that I last saw h[illegible] alive on Jan 20, 1927, and that death occurred, on the date stated above, at 6 m.

The CAUSE OF DEATH* was as follows:

Diabetes Gangrene.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis + Diabetes (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas Smith, M. D.

1/20 1927 (Address) 4702 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery

DATE OF BURIAL: Jan. 22 1927

20 UNDERTAKER: Eleanor J. Reith

ADDRESS: 1735 Harford Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

# E 18152 HEALTH DEPARTMENT—CITY OF BALTIMORE E 18152

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 916 N. Eden St. 10-14 Ward) 101-801

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph M. Neil

(a) Residence No. 916 N. Eden St., ..... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male | 4-COLOR OR RACE, White | 5-Single, Married, ~~Widowed, or Divorced~~ (Write the word) Married

5a-If married, ~~widowed, or divorced~~ HUSBAND of (~~or~~) WIFE of Adeline Neil

6-DATE OF BIRTH (month, day and year) 5. 25. 75

7-AGE, 51 yrs. 7 mos. 25 ds. | If LESS than 1 day, .... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer 10

(b) General nature of industry, business, or establishment in which employed (or employer) Millwork

(c) Name of employer Central Electric

9-BIRTHPLACE (city or town) Troy, (State or Country), N. Y.

PARENTS.

10-NAME OF FATHER, John Neil

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Eng. and

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) Troy (State or Country), N. Y.

14- (Informant) Madeline Neil

(Address) 916 N. Eden st.

15- Filed ..... 192 ..... Registrar.

C. HARPER JONES, M. D.

JAN 1 1927

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 1. 1927

17- I HEREBY CERTIFY, That I attended deceased from December 20 26 to Jan 1 27, 19..., that I last saw him alive on January 1 19 27, and that death occurred, on the date stated above, at 11 PM.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Collateral Edema

(Duration) 12 yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Harry H. A. Meyer M. D.

20, 1927 (Address) 1031 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19-PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL, Jan 24 1927 |
|---|---|
| Holy Cross Cemetery | |
| 20-UNDERTAKER, Robt G Turner Sr | ADDRESS 1542 Broadway |

Spec.—1-10-21—M&T—1500 Bks.

Dr. Whittle

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18153

## CERTIFICATE OF DEATH.

129 E 18153

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1787 Riverside ave ST. 24-33 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John R. Skillman

(a) RESIDENCE NO. 1787 Riverside ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ellen Skillman

6 DATE OF BIRTH (month, day, and year) Mar. 17th 1852

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or ..... min. |
|---|---|---|---|---|
| | 74 | 10 | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman, Grain Elevator (Retired)

(b) General nature of Industry, business, or establishment in which employed (or employer) 073

(c) Name of employer B. & O. R. R. Co.

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. J. R. Skillman (Address) 1787 Riverside ave.

15 Filed JAN 21 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 19th 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept 31, 1926, to Jan 19, 1927,

that I last saw him alive on Jan 19, 1927,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Chronic Nephritis + general arteriosclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C. Whittle, M. D.

1/21 1927 (Address) 1709 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery — DATE OF BURIAL 1/21/1927

20 UNDERTAKER D. J. Fanning & Son — ADDRESS 1140 Battery ave.

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18154 — CERTIFICATE OF DEATH. — 129 E 18154

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1725 Park Ave ST. 14-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Hardesty Worthington

(a) RESIDENCE No. 1725 Park Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): Widowed

If married, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of: Widowed

DATE OF BIRTH (month, day, and year): Dec 1st 1872

| AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 54 | 1 | 19 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Court House 009

(b) General nature of industry, business, or establishment in which employed (or employer): Chief Deputy Clerk

(c) Name of employer: in Circuit Court No 2

BIRTHPLACE (city or town) (State or country): Baltimore Maryland

10 NAME OF FATHER: Wm Cooke Worthington

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: S Hardesty

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

Informant: Mr Richard A Thompson

(Address): 141 Equitable Bldg.

Filed JAN 21 1927 C. HARPER JONES, M.D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 20th 1927

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1926, to Jan 19, 1927

that I last saw h[illegible] alive on Jan 19, 1927

and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 9 mos + ds.

CONTRIBUTORY (Secondary): Uraemia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Standish McBlevy, M. D.

1/20 1927 (Address) 1609 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery

DATE OF BURIAL: Jan 22 1927

20 UNDERTAKER: Henry Watkins & Son Co

ADDRESS: Richard & Pine Sts

pec.—1-12 23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18155

## CERTIFICATE OF DEATH.

E 18155

REGISTERED No. 90 25 25

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 47 S. Second St. Brooklyn

2-FULL NAME John S. Walter

(a) RESIDENCE NO. 47 S. Second ST., Brooklyn

(Usual place of abode) WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

a If married, widowed, or divorced HUSBAND of or) WIFE of Margaret Ruby Walter

DATE OF BIRTH (month, day, and year) Nov. 27, 1870

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 56 | 1 | 28 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Conductor

(b) General nature of industry, business, or establishment in which employed (or employer) B & O. R. R. Co

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md

10 NAME OF FATHER John S. Walter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Louisiana

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Earl Walter

(Address) 47 S. Second St.

Filed JAN 21 1927 C. HARRY JONES, M.D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 19th 1927

17

I HEREBY CERTIFY, That I attended deceased from July 2nd, 1926 to Jan. 19th, 1927.

and I last saw h[illegible] alive on Jan. 18th, 1927.

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Chronic aortic regurgitation of heart

(duration) — yrs. 6 mos 17 ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Otto Heidel M.D.

1/21, 1927 (Address) 124 26 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross C.A.Co.

DATE OF BURIAL 1/22 1927

20 UNDERTAKER Margaret S. Flynn

ADDRESS 1422 Light St.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18156

E 18156

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 27-47

City of BALTIMORE: (No. South Baltimore General Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edith Fangman

(a) RESIDENCE NO. 13 Jackson Ave Grandeville

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: aug. Fangman

6 DATE OF BIRTH (month, day, and year): sept. 8. 1900

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 26 | 4 | 12 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): atlanta, Ga,

PARENTS

10 NAME OF FATHER: alfred Vitelozzi

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Europe

12 MAIDEN NAME OF MOTHER: Niobe Castegnetti

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Europe

14 Informant (Address): Mrs. Mobe Vitelozzi 13 Jackson ave. G

15 Filed JAN 21 1927 19 C. HARRISON JONES Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): January 20th 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 17 1927, to Jan 20, 1927, that I last saw h e alive on Jan 21, 1927, and that death occurred, on the date stated above, at 12-10 p m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & Nephritis

(duration) yrs. mos. 8 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of Jan 17, 1927

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

, 19 (Address) 8 W 4 Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem

Date of Burial: Jan 24 1927

20 UNDERTAKER: Margaret G. Flynn

ADDRESS: 1422 Light St.

Spec.—12-9-25—A Co.—200 Eks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18157

18157

## CERTIFICATE OF DEATH.

161-001

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 249 S. Ann St. 2-4 Ward)

2-FULL NAME Infant Kowalski

(a) RESIDENCE NO. 249 S. Ann St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1/20/27

7 AGE: Years ____ Months ____ Days ____ IF LESS than 1 day ____ hrs. or 1 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) ____

(c) Name of employer ____

9 BIRTHPLACE (city or town) ____

(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Stephen Kowalski

11 BIRTHPLACE OF FATHER (city or town) ____

(State or country) Poland

12 MAIDEN NAME OF MOTHER Kathryn Ambrozy

13 BIRTHPLACE OF MOTHER (city or town) ____

(State or country) Poland

14 Informant Mrs Kowalski

(Address) 249 S Ann St

C. THOMPSON JONES, M. D.

15 Filed JAN 21 1927, 19__ Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/20 1927

17 I HEREBY CERTIFY, that I attended deceased from 1/20, 1927, to 1/20, 1927, that I last saw h[illegible] alive on 1/20, 1927, and that death occurred, on the date stated above, at ____ m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) asthma

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? ____

Did an operation precede death? N O Date of ____

Was there an autopsy? N O

What test confirmed diagnosis? Sign & symptoms

(Signed) Jay A Ambrose, M. D.

1/20, 1927 (Address) 1622 E North

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Date of Burial Jan 21 1927

20 UNDERTAKER J W Ozarowski ADDRESS 1930 Eastern Ave

Spec–12-23-21–E.B.R.S.–400 Bks. (Daisye H Kidwell) ✓

# HEALTH DEPARTMENT—CITY OF BALTIMORE

65-002

E 18158

## CERTIFICATE OF DEATH.

Registered No. E 18158

1-PLACE OF DEATH

City of BALTIMORE: (No. 4105 Groveland Ave St., 28-63 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Daisye H. Kidwell

(a) Residence No. 4105 Groveland Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. 11 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female.

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Chas. Frank Kidwell.

6-DATE OF BIRTH (month, day and year) Feb. 10 1879

7-AGE. 47 yrs. 11 mos. 10 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9-BIRTHPLACE (city or town). (State or Country). Maryland.

PARENTS.

10-NAME OF FATHER, Peter S Hunter

11-BIRTHPLACE OF FATHER (city or town). (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER, Elizabeth Bacon

13-BIRTHPLACE OF MOTHER (city or town). (State or Country), Maryland.

14-(Informant) Chas Frank Kidwell

(Address) 4105 Groveland Ave

15-Filed JAN 21 1927, 192. HAMPSON JONES, M. D. Registrar. By

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 1-20-27

17- I HEREBY CERTIFY, That I attended deceased from July 15th 1926 to Jan. 20th 1927.

that I last saw her alive on Jan. 20th 1927

and that death occurred, on the date stated above, at 1:30 P m.

The CAUSE OF DEATH* was as follows:

Hodgkins Disease

(Duration) 2 yrs. mos. ds

CONTRIBUTORY (Secondary) Cardiac asthenia.

(Duration) yrs. mos. ds

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) M. B. Byerly M. D

19 (Address) 3524 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Woodlawn. Cem

DATE OF BURIAL. 1-22-27 19

20-UNDERTAKER. Earl B Hale

ADDRESS 115 E West St.

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 18159 — 90 E 18159

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 5749 Park Heights Ave St. 27-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William C. Griffin

(a) RESIDENCE NO. 5749 Park Heights Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Julia.

6 DATE OF BIRTH (month, day, and year): Sept 23, 1868

7 AGE — Years: 58 — Months: 3 — Days: 25 — IF LESS than 1 day ..hrs. or ..min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Builder

(b) General nature of industry, business, or establishment in which employed (or employer): Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Nathaniel Griffin

11 BIRTHPLACE OF FATHER (City or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: William C. Griffin

(Address) 3502 Furrow Rd

15 Filed 12-1 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: Jan. 20 27

17 I HEREBY CERTIFY, That I attended deceased from Jan 11, 19 27, to Jan 20, 19 27

that I last saw him alive on Jan 20, 19 27

and that death occurred, on the date stated above, at 1-32 m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Clinical

What test confirmed diagnosis?

(Signed) Charles J Wells, M. D.

, 19 (Address) 5242 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Jan 22 1927 — Date of Burial

20 UNDERTAKER: H. Cook — ADDRESS: 502 E Fayette

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18160

## CERTIFICATE OF DEATH

129 E 18160

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 4047 N. Caroline St. 5-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Johnson

(a) RESIDENCE NO. 4047 N. Caroline St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Colored | widower |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Johnson

6 DATE OF BIRTH (month, day, and year) 1877

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min.. |
|---|---|---|---|---|
| 50 | 49 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind af work Housework

(b) General nature of industry, business, or establishment in whieh employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimd.

(State or country)

PARENTS

10 NAME OF FATHER Primus Johnson

11 BIRTHPLACE OF FATHER (City or town) S. C.

(State or country)

12 MAIDEN NAME OF MOTHER Lucy Dixon

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Newton Johnson

(Address) 604 N. Patterson Pk.

15 Filed JAN 21 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 5, 1927, to Jan 19, 1927, that I last saw h[illegible] alive on Jan 19, 1927, and that death occurred, on the date stated above, at 9.50 P m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

Chronic Nephritis

(duration) yrs. mos. da.

CONTRIBUTORY Influenza

(Secondary)

(duration) yrs. mos. 2 da.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Data of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Benj Hamm, M. D.

, 19 (Address) 345 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Aecidental, Suicidal, or Homicidal. (See reverse sida for additional spaee.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery Date of Burial Jan. 22 1927

20 UNDERTAKER Chris. H. Johnson ADDRESS 416 N. Carolina St.

Very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18161

## CERTIFICATE OF DEATH.

101-091

E 18161

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital 4-7 St., Ward)

2-FULL NAME Theodore Coleman

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(a) RESIDENCE NO. — St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 21 Months Days

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 087

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant

(Address)

15 1927 C. HAMPSON JONES, M. D.

Per RPW Registrar

(X)(T) THE MORGUE

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24 1926

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest

(Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) W. S. Peters M. D.

(Coroner)

Jan 19 1927 (Address) 1639 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

Date of Burial 19

20 UNDERTAKER

ADDRESS

Commissioner of Health

JAN 21 1927

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18162

## CERTIFICATE OF DEATH.

E 18162

22-6 18 1-001

1-PLACE OF DEATH

REGISTERED NO._____

City of BALTIMORE: (No. 20 W. Lee St. St. 22-6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John J. Winslow.

(a) RESIDENCE NO. Mt. Pleasant, Delaware. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male. | White | Do not know. |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| about 65 | ---------- | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Do not know.

(b) General nature of industry, business, or establishment in which employed (or employer) 07

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) Do not know.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Do not know.

14 Informant Police Report. S.D.

(Address)

15 Dec. 27 19 C. HAMPSON JONES, M. D.

1927 Per _____ Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 29, 1926 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Occidental Illuminating gas Asphyxia. defective gas cock.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

(duration) .....yrs. .....mos. .....ds.

(Signed) Otto Reinhardt (Coroner) M. D.

1/20 19 27 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial 19 |
|---|---|
| JOHNS HOPKINS HOSPITAL | |
| 20 UNDERTAKER | ADDRESS |
| Deputy Health Commissioner | JAN 21 1927 |

972 THE MORGUE.

Spec.—7-17-26—A Co.—200 Blks.

E 18163

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

74001

E 18163

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 308 S. Eastle St. 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Baum.

(a) RESIDENCE NO. 308 S. Eastle St. 2 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. 3 mos. 6 ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late George Baum.

6 DATE OF BIRTH (month, day, and year) Oct. 12th 1859

7 AGE

| Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|
| 67 | 3 | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER Nicholas Seifert

11 BIRTHPLACE OF FATHER (City or town) Germany

(State or country)

12 MAIDEN NAME OF MOTHER Francis

13 BIRTHPLACE OF MOTHER (city or town) Germany

(State or country)

14 Informant Fred. Baum

(Address) 915 N. Ellwood Ave.

15 1927 C. HAMPSON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 6, 1927, to Jan 18, 1927, that I last saw h[illegible] alive on Jan 17, 1927, and that death occurred, on the date stated above, at 9 30 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 13 ds.

18 Where was disease contracted

if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Leckie Hess, M. D.

1.20, 1927 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — Date of Burial: Jan. 22nd 1927

20 UNDERTAKER: Lilly + Zeiler — ADDRESS: 403 S. Wolfe St

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18164

E 18164

## CERTIFICATE OF DEATH.

2-30 90

1-PLACE OF DEATH

City of BALTIMORE: (No. 419 Hanover St. St. 2 Ward

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry L. Shinkle.

(a) RESIDENCE NO. 419 Hanover St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male. | White. | Single. |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) October 9, 1899.

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 27 | 3 | 11 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer) B.C.& A.R.R.Co.

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Indianapolis, Ind.

PARENTS

10 NAME OF FATHER John E. Shinkle.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Kentucky.

12 MAIDEN NAME OF MOTHER Nellie E. Fetzer.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Indiana.

14 Informant Nellie E. Shinkle. (mother)

(Address) 419 Hanover St.

15 1927 C. HANSON JONES, M. D. Registrar

Dur ----

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 20, 1927. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insuffieieney.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) Otto M. Reinhardt M. D.

(Coroner)

1/20 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem. Date of Burial June 5 1927

20 UNDERTAKER E. Schlossmacher ADDRESS 1039 Hanover St.

Spec.—1-10-21—M&T—1500 Bks.

E 18165

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18165

## CERTIFICATE OF DEATH.

1-287

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 37 S. East Ave ST., [illegible] WARD)

2-FULL NAME Evelyn Bramble

(a) RESIDENCE NO. 37 S. East Ave ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 23 1906

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 20 | 9 | 27 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER George S. Bramble

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Mary Minck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant (Address) Mrs Mary Bramble 37 S East Ave.

Filed JAN 1927 C. HAMPSON JONES, M. D., Registrar

Per [illegible]

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 19 1927

17

I HEREBY CERTIFY, That I attended deceased from January 15, 1927, to Jan 19, 1927.

That I last saw her alive on Jan 19, 1927.

and that death occurred, on the date stated above, at 7 15 a m.

The CAUSE OF DEATH* was as follows:

Chronic Pericarditis

(duration) 5 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis

(duration) 15 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph L. Valentine M. D.

19 (Address) 14 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Oak Lawn Cemetery | Jan 22 1927 |

20 UNDERTAKER John Ulrich ADDRESS Eastern

Spec—12-23-21—E.B.R.S.—400 Bks.

18166

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18166

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1933 W. Lexington St. Ward) 154

Registered No. 1927

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anthony D'Alfonzo

(a) Residence No. 1933 W. Lexington St. St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE. W

5-Single, Married, Widowed or Divorced. (Write the word.) S.

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 3-1926

7-AGE, ..... yrs. 7 mos. 17 ds.

If LESS than 1 day, ....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER Anthony D'Alfonzo

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Italy

12-MAIDEN NAME OF MOTHER Jennie D'Alfonzo

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Italy

14- (Informant) Anthony D'Alfonzo

(Address) 1933 W. Lexington St

15- Filed ..... 19 C. HAMPSON JONES, M. D. Registrar.

Jan 1927 Per

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 20 - 27

17- I HEREBY CERTIFY, That I attended deceased from June 3, 1926, to Jan 20, 1927

that I last saw him alive on Jan 20, 1927

and that death occurred, on the date stated above, at 5:20 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

Sclerosis of Cerebral Arteries

Toxic Spasms Sinus

Tachycardia (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Thrombosis

(Congenital) (Duration) yrs. mos. ds.

18-Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jos. L. Holmes M. D.

Jan 21, 1927 (Address) 14 So Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Cathedral

DATE OF BURIAL. Jan 22 1927

20-UNDERTAKER. Wm Cook.

ADDRESS 512 North Gay

Spec—12-23-21—E.B.R.S.—400 Bks.

18167 HEALTH DEPARTMENT—CITY OF BALTIMORE E 18167

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2527 Ashton St. 20 6 19 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... John T. Knight.

(a) Residence No. 2527 Ashton St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

### PERSONAL AND STATISTICAL PARTICULARS.

| 3-SEX | 4-COLOR OR RACE | 5-Single, Married, Widowed, or Divorced, (Write the word.) |
|---|---|---|
| Male | White | Widowed. |

5a-If married, ~~widowed, or divorced~~ HUSBAND ~~of (or) WIFE of~~ Laura V. Knight.

6-DATE OF BIRTH (month, day and year) Dec. 2-1839

| 7-AGE | If LESS than 1 day |
|---|---|
| 87 yrs. 1 mos. 18 ds. | ....hrs. or....min.? |

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... Spring Maker.
(b) General nature of industry, business, or establishment in which employed (or employer)..... — Ob
(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Md.
(State or Country),

PARENTS.

10-NAME OF FATHER, Wm. H. Knight.

11-BIRTHPLACE OF FATHER (city or town) Unknown.
(State or Country),

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) Unknown
(State or Country),

14- (Informant) Miss Mollie Knight
(Address) 2527 Ashton St.

15- Filed 1927 C. HAMPSON JONES, M. D. Registrar.
Per — ARL

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan. 20-1927

17- I HEREBY CERTIFY, That I attended deceased from Jan 15 1927 to Jan 20 1927
That I last saw h— alive on Jan 20 1927
and that death occurred, on the date stated above, at 1 P. m.
The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) T. J. Klussman M. D.

Jan 21. 1927 (Address) 2487 Westen Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19-PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Baltimore Cemetery | Jan. 22 1927. |
| 20-UNDERTAKER. Charles J. Schwab | ADDRESS 505 N. Monroe St. |

Spec.—12-9-25—A Co.—200 Bks.

E 18168

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18168

## CERTIFICATE OF DEATH.

X 101-0

1-PLACE OF DEATH

City of BALTIMORE: (No. 733 Linnard St. 16 Ward) 16-67

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth A. Ashby

(a) RESIDENCE NO. 733 Linnard St. Ward Merchantville N. J.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 Color or Race White

5 Single, Married, Widowed, or Divorced. (write the word) Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 15—1877

7 AGE Years 49 Months 6 Days 5 If LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Camden N. J.

(State or country)

PARENTS

10 NAME OF FATHER Robt. Keefe

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret McManus

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Wm E. Garvey

(Address) 733 Linnard St.

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20— 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 13 1927 to Jan 20 1927,

that I last saw h... alive on Jan 20 1927,

and that death occurred, on the date stated above, at 6 A.M. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical Findings

(Signed) Geo. L. Wrage, M. D.

, 19 (Address) 4000 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Calvary Cem. Camden N. J. Date of Burial 1/22 1927

20 UNDERTAKER Chas. F. Grove & Son ADDRESS 1181 Mt Royal

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18169

## CERTIFICATE OF DEATH. E 18169

REGISTERED NO.

1-PLACE OF DEATH St Josephs Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Caroline & Oliver ST. 12-50 WARD)

2-FULL NAME Helen Harmon

(a) RESIDENCE NO. 2419 Guilford Ave ST., ..... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 23-1908

| AGE | Years | Months | Days | If LESS than 1 day, hrs or min |
|---|---|---|---|---|
| | 18 | 5 | 27 28 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stenog

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Harry Harmon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Nannie Roddy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

Informant Harry Harmon

(Address) 2419 Guilford Ave

Filed 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 20, 1927, to Jan 27 21, 1927.

That I last saw h=C alive on Jan 27 21, 1927,

and that death occurred, on the date stated above, at 3:00 p.m.

The CAUSE OF DEATH* was as follows:

Encephalitis

(duration) yrs. mos 2 wks 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of

Was there an autopsy? None

What test confirmed diagnosis? clinical.

(Signed) H C McConnell, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: 1/31, 1927

UNDERTAKER: Chas S. Crane & Son

ADDRESS: 118 W. Mt. Royal ave

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18170

## CERTIFICATE OF DEATH

90 E 18170

1-PLACE OF DEATH St. Agnes Hospital

REGISTERED NO. 30570

City of BALTIMORE: (No. ..... Ward or Ward Board)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Grason Mc. Cubbins

(a) RESIDENCE NO. 3226 Leeds St & 11th St. Ward St. Agnes ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. da. How long in U. S. if of foreign birth? yrs. mos. da.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, (Married) Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mrs. Mary Cubbins.

6 DATE OF BIRTH (month, day, and year) May 18–1875

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|---|
| | 51 | 8 | 2 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer) not

(r) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER William Mc Cubbins

11 BIRTHPLACE OF FATHER (City or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary Hunt

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Mrs. Mary Mc Cubbins
(Address) 3226 Leeds St City

15 Filed ..... 19 .....
1927 C. HAMPSON JONES, M. D. Registrar
By .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1 – 20 1927

17 I HEREBY CERTIFY, That I attended deceased from 1-18- 1927 to 1-20 1927

that I last saw him alive on 1-20 1927

and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency
following cerebral hemorrhage
right side
(duration) ..... yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary) Chronic cardio-renal hypertension
disease (duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Sheron Kinsler M. D.

1/20. 1927 (Address) St. Agnes' Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — Date of Burial 1/24 1927

20 UNDERTAKER Chas. S. Manertson — ADDRESS 1181 W. Baltimore

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18171

## CERTIFICATE OF DEATH.

90 E 18171

1-PLACE OF DEATH

City of BALTIMORE: (No. 1102 N. Eutaw St. 11-24 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie M. Devall

(a) RESIDENCE NO. 1102 N. Eutaw St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Devall

6 DATE OF BIRTH (month, day and year): Unknown

7 AGE: Years 70 Months — Days — If LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: John Ward

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Campbell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Wm Devall (Address) 102 N. Eutaw St.

15 Filed, 19 27 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 21 19 27

17 I HEREBY CERTIFY, That I attended deceased from Jany 16 19 27 to Jany 21 19 27, that I last saw h[illegible] alive on Jany 20 19 27, and that death occurred, on the date stated above, at 3,15 A m.

The CAUSE OF DEATH* was as follows:

Acute myocarditis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary): Mitral Heart Disease Embolism

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm O'Neill M. D.

1/21, 19 27 (Address) 10 E. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery Date of Burial 1/24 19 27

20 UNDERTAKER: Chas F. Evans & Son ADDRESS 118 W. Mt Royal Ave

Spec.—1-10-21—M&T—1500 Blks.

E 18172

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18172

## CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mt Washington Druid Ave + Highland Ave (St.) 27 (Ward) 54

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Francis Sullivan

(a) RESIDENCE NO. 1008 Druid Avenue + Highland Ave ST., 27 WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | white | married |

5a If married, widowed or divorced HUSBAND of (or) WIFE of Emma Burgess Sullivan

6 DATE OF BIRTH (month, day, and year) Aug 27, 1860

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 66 | 4 | 23 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer & Molder

(b) General nature of industry, business, or establishment in which employed (or employer) Plumbing Supplies

(c) Name of employer Partner

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John F. Sullivan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Emma Lorsch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Harold L. Bennett (Address) Baltimore Md

15 Filed , 19 CHAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany. 20 1927

17 I HEREBY CERTIFY, That I attended deceased from Jany 5 , 1927 , to Jany 20 , 1927 . that I last saw him alive on Jany 20 , 1927 and that death occurred, on the date stated above, at 12 noon.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 0 yrs. 0 mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Symptoms

(Signed) Thomas J. Ford, M. D.

, 19 (Address) Mt Washington Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: 1/24 1927

UNDERTAKER: Chas P. Crane & Son — ADDRESS: 118 W. Lexington St

Spec—12-23-21—E.B.R.S.—400 Bks.

E 18173

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18173

## CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

Registered No.

City of BALTIMORE: (No. 3004 Dillon St., 1st (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Ernestine Eyles

(a) Residence No. 3004 Dillon St. St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of none

6-DATE OF BIRTH (month, day and year) Dec 28 1910

7-AGE. 16 yrs. 2 mos. 23 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) Schoolgirl

(c) Name of employer none

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Albert Eyles

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Maryland

12-MAIDEN NAME OF MOTHER, Johanna Bierman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

14-

(Informant) Albert Eyles

(Address) 3004 Dillon St.

15-

Filed 1927 C. HAMPSON JONES, M. D. Registrar.

Per

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 20 27

17- I HEREBY CERTIFY, That I attended deceased from Dec 1, 1926 to Jan 20 1927 that I last saw her alive on Jan 19, 1927 and that death occurred, on the date stated above, at 9 A.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Toxemia + exhaustion

(Duration) yrs. mos. 2 ds. +

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

1/21/1927 (Address) 1014 S. Ellwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St. Paul's Cemetery

DATE OF BURIAL. Jan. 23, 1927

20-UNDERTAKER. Henry Sander & Sons Inc

ADDRESS 1710 Fleet St

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18174

CERTIFICATE OF DEATH.

90 E 18174

1-PLACE OF DEATH 822 N. Carrollton Ave

REGISTERED NO.

City of BALTIMORE: (No. Presbyterian Home of Maryland St. 16 Ward 23

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie E. Johnston

(a) RESIDENCE NO. 822 N. Carrollton Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 11 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feby 16 1851

7 AGE: Years 75 | Months 11 | Days 4 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer:

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER John Johnston

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Hughes

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Records

(Address) Presbyterian Home

15 Date 1927 By C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1926, to Jan 20, 1927, that I last saw h[illegible] alive on Jan 18, 1927, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Atypical Cells

(Signed) J. M. Lumpkin, M. D.

Jan 21 1927 (Address) 826 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — Date of Burial Jan 22 1927

20 UNDERTAKER: Chas. G. Black — ADDRESS 742 W. North Ave

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18175

# CERTIFICATE OF DEATH.

90 E 18175

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2707 Elsinor Ave St. 15-61 Ward)

2-FULL NAME Mary A. G. Williams

(a) RESIDENCE NO. 2707 Elsinor ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 8 mos. ds. 6 How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | white | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John W. Williams

6 DATE OF BIRTH (month, day, and year) May 14 1864

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 62 | 8 | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER William E Mason

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Md

12 MAIDEN NAME OF MOTHER Mary C. Burbe

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Md.

14 Informant John W. Williams

(Address) 2707 Elsinor ave

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Jany 20 27

17 I HEREBY CERTIFY, That I attended deceased from Jany 25 1924 to Jany 20 1927, that I last saw h alive on Jany 20 1927, and that death occurred, on the date stated above, at 1.55 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Decompensation

(duration) yrs. mos. 15 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) J. W. Thomas, M. D.

(Address) 1238 W Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery Date of Burial Jan 22 1927

20 UNDERTAKER Chas. J. Black & Bro. ADDRESS W. North Ave

Spec.—1-12-23—M&T—500 Bks.

98396
E 18176

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 18176

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7-9 WARD)

2-FULL NAME William Murphy

(a) RESIDENCE NO. Cunningham Av Va. ST., — WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Virginia -

6 DATE OF BIRTH (month, day, and year) [illegible]

| 7 AGE Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|
| 77 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer -

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. Va -

PARENTS

10 NAME OF FATHER Wm Murphy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Cynthia Lucky

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va.

14 Informant Records -

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 1 1927, 19 C. HAMPSON JONES, M. D. Per [illegible] Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 21 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1926, to Jan 21, 1927, that I last saw h[illegible] alive on Jan. 21, 1927 and that death occurred, on the date stated above, at 8 45 a.m.

The CAUSE OF DEATH* was as follows:

CC Cerebral Embolus

Auricular Fibrillation

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Benign Prostatic Hypertrophy

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? do

Did an operation precede death? Yes Date of 1/10/27

Was there an autopsy? do

What test confirmed diagnosis?

(Signed) [illegible], M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Mannington W Va | 1/21/27 |
| 20 UNDERTAKER Joseph Ahrens | ADDRESS 22 N Eutaw St |

Spec.—1-12-23—M&T—500 Bks.

18177

# HEALTH DEPARTMENT—CITY OF BALTIMORE

160 E 18177

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2029 Fleet St. W-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thirdie Crounse

(a) RESIDENCE NO. 2029 Fleet ST, ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Infant

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year): Jan 14, 1927.

7 AGE — Years: — Months: — Days: 8. If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

10 NAME OF FATHER: Thirdie Crounse

11 BIRTHPLACE OF FATHER (city or town) (State or country): Annapolis County

12 MAIDEN NAME OF MOTHER: Blyth Lassiter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Laurel Miss

14 Informant (Address): Thirdie Crounse 2029 Fleet St

15 FILED 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 21 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 14, 1927, to Jan. 21, 1927, that I last saw h[illegible] alive on Jan. 21, 1927 and that death occurred, on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:

Acute Yellow Jaundice at birth.

(duration) ..... yrs. ..... mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P. S. & S.

(Signed) John V. Sezerlachin, M. D.

, 19 (Address) 735 E. Fairmount Ave T.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION ~~OR~~ REMOVAL: Lehmaster — DATE OF BURIAL: Jan 13 1927

20 UNDERTAKER: Wendell J. Hoppel — ADDRESS: 300 E Fair

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18178

CERTIFICATE OF DEATH.

100-001

E 18178

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1308 E Pratt St., 3-5 Ward)

2-FULL NAME Mike Matelyky

(a) RESIDENCE NO. 1308 E Pratt St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. mos. da.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. da.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Matelyky

6 DATE OF BIRTH (month, day, and year) Not Known

| 7 AGE Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|
| 46. | 4 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) 015

(c) Name of employer

9 BIRTHPLACE (city or town) Poland

(State or country)

PARENTS

10 NAME OF FATHER Wasalaw Matelyky

11 BIRTHPLACE OF FATHER (city or town) Poland

(State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Poland

(State or country)

14 Informant Nicholas Matelyky

(Address) 1308 E Pratt St

1927 C. HAMPSON JONES, M. D. Registrar

Per _____

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Broncho Pneumonia

(duration) yrs. mos. 2 da.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 da.

Jan 21 1927 (Signed) C. E. Pratt M. D. (Coroner)

(Address) 143 W 13 mo

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Trinity Russian Cem Date of Burial Jan 22 1927

20 UNDERTAKER Wendell J Heppel ADDRESS 300 E Eden St

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E·18179

## CERTIFICATE OF DEATH

90 E·18179

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 503 S. Bouldin St. 16-2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter P. Nowakowski

(a) RESIDENCE NO. 503 S Bouldin St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S. if of foreign birth 22 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 29 1890

| 7 AGE | Years | Months | Days | IF LESS than 1 day ... hrs. or ... min. |
|---|---|---|---|---|
| | 36 | 6 | 22 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Poland

(State or country)

PARENTS

10 NAME OF FATHER Peter P. Nowakowski

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Frances Olawski

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Mrs. Stanislawa Nowakowski

(Address) 503 S. Bouldin St

15 C. HAMPSON JONES, M. D.

JAN 1927 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 19, 1927, to Jan. 20, 1927,

that I last saw h alive on Jan. 20, 1927,

and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

Myocardial Degeneration

(duration) yrs. mos. ds.

CONTRIBUTORY —

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted —

if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Andrew Kantorowitz, M. D.

19 27 (Address) 2039 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Holy Rosary | Jan 24 19 27 |

20 UNDERTAKER John M. Ahlers ADDRESS 1803 Bank St

Spec.—1-12-28—M&T—500 Blks.

19936

E 18180

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

37 E 18180

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ) ST. 23-31 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nathaniel Lee

(a) RESIDENCE NO. 1045 S. Sharp. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | Col | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4-22-1924

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 2 | 8 | 27 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Henry Lee

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)

12 MAIDEN NAME OF MOTHER Jessie Savage

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant Records - (Address) JOHNS HOPKINS HOSPITAL

15 Filed Jan 27 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 18, 1927 to Jan 19, 1927 that I last saw h alive on Jan 19, 1927 and that death occurred, on the date stated above, at 5 45 P m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) Home

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray - Lumbar puncture

(Signed) Thomas W. Worthington, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount

DATE OF BURIAL Jan. 22 1927

20 UNDERTAKER Walter B. Speir

ADDRESS 1194 W. Hamburg St.

Spec.—8-24-14—M. & T.—2000 Bks.

E 18181 HEALTH DEPARTMENT—CITY OF BALTIMORE E 18181

## CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3308 Ridgewood Ave ST. 15-61 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Raymond Earl Reed

(Residence in Baltimore: No. 3308 Ridgewood Ave St.: 40 yrs., mos. 24 ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, OR ~~DIVORCED~~. (*Write* the word.)

6-DATE OF BIRTH, Dec. 23, 1886 (Month) (Day) (Year)

7-AGE. 40 yrs. 25 mos. 29 ds. If LESS than 1 day, ....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter 015
(b) General nature of industry, business, or establishment in which employed (or employer): Wood work

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Louis S Reed.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Carrie Flowers

13-BIRTHPLACE OF MOTHER (State or Country), Harford Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Adeline Reed

(Address) 3308 Ridgewood Ave

15- C. HAMPSON JONES, M. D.

Filed JAN 22 1927, 191.... Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 21, 1927 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 1 1927, to Jan. 21 1927, that I saw him alive on Jan. 19 1927, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(Duration) yrs. 4 mos. ds.

(Signed) A M Evans M. D.

Jan. 21, 1927 (Address) 1475 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn — DATE OF BURIAL, Jan 24 1927

20-UNDERTAKER Eichenwald & Son — ADDRESS 3617 Chestnut Ave

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 18182

# CERTIFICATE OF DEATH

E 18182

1-PLACE OF DEATH 3813 Pleasant Place

REGISTERED NO.

City of BALTIMORE: (No. 13-5 St. 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Master R Johnson

(a) RESIDENCE NO. 3813 Pleasant Place St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1/12 mos. da. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) October 9, 1926

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | | 3 | 11 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Ashton Johnson

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Lydia Vermillion

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Ashton Johnson

(Address) 3813 Pleasant Pl

15 Filed 2 1927 C. HAMPSON JONES, M. D. Registrar

Per

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 19, 1927, to Jan 20, 1927.

that I last saw h alive on Jan 20, 1927,

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clin. Signs

(Signed) John E Norment M. D.

. 19 (Address) 3543 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Hampden Date of Burial Jan 21 1927

20 UNDERTAKER Ehrenwerth Son ADDRESS 3617 Chestnut Ave

Cor.—12-9-25—A Co—200 Bks.

E 18183

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

181-004

E 18183

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hosp. St. 4-25 Ward)

2-FULL NAME Lee Ang

(a) RESIDENCE NO. 210 N Bentley St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | Mongolian | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) not known

| 7 AGE— | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| about | 61 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Gr

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) China

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) East Indies

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Lee Ang

(Address) Eastern Cemetery

15 1927 C. HAMPSON JONES, M. D.

Per _____ Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/18 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carbon monoxide poisoning

accidental

improper combustion of stove

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary)

(duration) ___ yrs. ___ mos. ___ ds.

(Signed) Albert Mahn M. D.

(Coroner)

, 1927 (Address) 3317 Putnam

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Mem Date of Burial Jan 22 1927

20 UNDERTAKER John C Mitchell ADDRESS 1201 W Fayette

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18184

# CERTIFICATE OF DEATH

118 E 18184

1-PLACE OF DEATH

City of BALTIMORE: (No.) St Agnes Hospital (Street) 20-69

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm J. Hyde Neddell

(a) RESIDENCE NO. 816 Whitemore Ave Ward

(Usual place of abode)

Length of residence in city or town where death occurred 83 yrs. 2 mos. 7 da. (If non-resident give city or town and State) How long in U. S. If of foreign birth? — yrs. — mos. — da.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary S. Neddell

6 DATE OF BIRTH (month, day, and year): Nov 23rd 1843

7 AGE: Years 83 Months 2 Days 7 IF LESS than 1 day ___ hrs. or ___ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Md

(State or country): Harford Co

PARENTS

10 NAME OF FATHER: Samuel Neddell

11 BIRTHPLACE OF FATHER (City or town): Unknown

(State or country)

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): Unknown

(State or country)

14 Informant: W. H. Hyde

(Address) 3520 Wilkens Ave

15 1927 C. HAMPSON JONES, M. D. Registrar

Pw ACH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 20th 27

17 I HEREBY CERTIFY, That I attended deceased from 1-18 1927 to 1-20 1927

that I last saw him alive on 1-20 1927

and that death occurred, on the date stated above, at 10:45 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(duration) ___ yrs. ___ mos. ___ da.

CONTRIBUTORY (Secondary) Strangulated Hernia

(duration) ___ yrs. ___ mos. 7 da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of 1-18-27

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Etherod Hunter M. D.

1/20 1927 (Address) St. Agnes' Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery Date of Burial Jan 22nd 1927

20 UNDERTAKER: F. S. Wippert ADDRESS 1850 W. Balto St

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18185 | E 18185

## CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 502 S. Eutaw St. 12-30 (Ward)

2-FULL NAME Alonzo Sliney.

(a) RESIDENCE NO. 502 S. Eutaw ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Col | married |

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Elmira Sliney

DATE OF BIRTH (month, day, and year) — 1886

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 41 | — | — | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. odd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Torch's Packing House

BIRTHPLACE (city or town) (State or country) Greensboro Maryland

10 NAME OF FATHER Joseph Sliney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greensboro Maryland

12 MAIDEN NAME OF MOTHER Annie Bulah

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Caroline Co Maryland

Informant Elmira Sliney

(Address) 502 S. Eutaw

Filed 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/20 1927

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1927, to 1/20, 1927, that I last saw him alive on June - 19, 1927 and that death occurred, on the date stated above, at 1/15 P. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(duration) — yrs. — mos 10 ds.

CONTRIBUTORY (Secondary) Chr. Endocarditis (duration) — yrs. — mos — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no —

What test confirmed diagnosis? none —

(Signed) Dr. Dranehm, M. D.

1/21/1927 (Address) 122 N Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Queenan's Md. | Jan 22 1927 |
| 20 UNDERTAKER Dennis Easton | ADDRESS Caroline |

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18186

## CERTIFICATE OF DEATH

129

E 18186

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No.) 4305 Maine Ave. St. (If Ward) 24-54

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Ann Brooks

(a) RESIDENCE NO. 4305 Maine Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 66 yrs. 11 mos. 0 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John T. Brooks

6 DATE OF BIRTH (month, day, and year): Dec. 20-1860

7 AGE — Years: 66 Months: 11 Days: 0 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Balto

(State or country): Md

PARENTS

10 NAME OF FATHER: John H. Reed

11 BIRTHPLACE OF FATHER (City or town): Balto

(State or country): Md

12 MAIDEN NAME OF MOTHER: Frances Zepher

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country): Md

14 Informant: Mrs. W. H. Baltemeyer

(Address): 4305 Maine Ave

1927 — C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 20 19 27

17 I HEREBY CERTIFY, That I attended deceased from Jan 22, 19 26, to Jan 22, 19 27, that I last saw h[illegible] alive on Jan 20 19 27, and that death occurred, on the data stated above, at 8 10 A.M.

The CAUSE OF DEATH* was as follows:

Pan-chronic tabes Neuro lues

& stasis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

by cardiac heart failure

(duration) yrs. mos. 5 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Wassermann Complement

(Signed) Riordan & Tom Dickey, M. D.

19 (Address) 908 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — Date of Burial: Jan 22 1927

20 UNDERTAKER: Wm. J. Pickett & Son — ADDRESS: N. Pa

Spec.—1-10-21—M&T—1500 Bks.

E 18187 HEALTH DEPARTMENT—CITY OF BALTIMORE E 18187

CERTIFICATE OF DEATH. 10

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2218 N. North Ave ST. 15-68 (WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Franklin Rhrade

(a) RESIDENCE NO. 2218 N. North Ave ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed,~~ or ~~Divorced,~~ (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 19 1924

7 AGE

| Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|
| 2 | 4 | 2 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER J. F. Rhrade

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn.

12 MAIDEN NAME OF MOTHER Anna Sifert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn

14 Informant Jos F. Rhrade
(Address) 2218 N. North Ave

15 Filed 2 1927 C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 21 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 15th 1927 to Jan 21st 1927.
that I last saw him alive on Jan 21 20 1927
and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Diphtheria
(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Cardiac failure
(duration) yrs. mos. 1½ ds.

18 Where was disease contracted if not at place of death? "

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Laboratory tests

(Signed) Walter C Bacon M. D.

1/21 1927 (Address) 100 E 20th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL Jan 22 1927

20 UNDERTAKER H. M. Cox — ADDRESS 502 E. N. Ave

Spec.—I-10-21—M&T—1500 Bks.

E 18188

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18188

## CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md General Hospital St. 98-64 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Annie May Gornell

(a) RESIDENCE NO. 5004 Fendale ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| F. | W | Married |

5a If married, widowed, or divorced (or) WIFE of Chas W. Gornell

6 DATE OF BIRTH (month, day, and year) May 8, 1866

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 60 | 8 | 13 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H W. 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Butler Md.

PARENTS

10 NAME OF FATHER Caleb H Bizzard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Tracy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maine

14 Informant Hospital Records (Address)

15 2 1927 C. HAMPSON JONES, M.D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-21 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 4 1927 to Jan 21 1927, that I last saw h alive on Jan 21 1927, and that death occurred, on the date stated above, at 4.45 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. C. Zimmerman M.D.

1927 (Address) Md Gen Hosp Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery DATE OF BURIAL Jan 24th 27

20 UNDERTAKER Putnam & Gore ADDRESS 1123 W Lafayette Ave

Spec.—1-10-21—M&T—1500 Bks.

E 18189

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 18189

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2118 E. Madison ST., 7-12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernadine Stromberg

(a) RESIDENCE No. 2118 E. Madison ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Infant |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) April 9, 1926

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | — | 9 | 11 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md

PARENTS

10 NAME OF FATHER William Stromberg

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Fonie Nemec

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant William Stromberg
(Address) 2118 E. Madison St

15 Filed JAN 22 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 20 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 10, 1927, to Jan. 20, 1927,

that I last saw her alive on Jan. 20, 1927

and that death occurred, on the date stated above, at 10 20 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia (Primary)

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Vincent P. Dzoka, M. D.

, 19 (Address) 845 N. Patterson Pk. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Jan 22 1927

20 UNDERTAKER Frank Crockson — ADDRESS 1906 Bank

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18190

## CERTIFICATE OF DEATH.

188-903 E 18190

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St. 6-10 Ward)

2-FULL NAME James Abel

(a) RESIDENCE NO. 18 N Madeira St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) [illegible]

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 41 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sawyer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country)

PARENTS

10 NAME OF FATHER John Abel

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Austria

12 MAIDEN NAME OF MOTHER Mary Sedivitz

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Austria

14 Informant Mrs. X Abel

(Address) 18 N Madeira St

Jan 25 1927 C. HAMPSON JONES, M. D.

Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

Thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

Multiple Fractures

(Duration) 1 yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Shock

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) C. Hampson Jones M. D.

(Coroner)

Jan 27, 1927 (Address) 143 N Gay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ____ yrs., ____ mos., ____ ds. In the State ____ yrs., ____ mos., ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Date of Burial Jan 31 1927

20 UNDERTAKER Frank Evans Son ADDRESS 1906 Eastern Ave

Spec.—12-9-25—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18191

## CERTIFICATE OF DEATH.

90 E 18191

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 3114 - Barclay St. 12-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Stein

(a) RESIDENCE NO. 3114 - Barclay St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: col

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Cora Stein

6 DATE OF BIRTH (month, day, and year): ~~Entered~~ May 1, 1850

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| 76 | — | 8 | 18 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) West Chester, Pa.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town):

(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) unknown

14 Informant: Mrs. Cora Stein

(Address) 3114 Barclay St

Date received JAN 22 1927

C. HAMPSON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1926 to Jan 19, 1927, that I last saw him alive on Jan 19, 1927, and that death occurred, on the date stated above, at 2:30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Heart Disease

(duration) ___ yrs. 1Y mos. ___ ds.

CONTRIBUTORY (Secondary)

(duration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted if not at place of death? Home death

Did an operation precede death? No Date of ___

Was there an autopsy? No

What test confirmed diagnosis? ___

(Signed) L. A. Johnson, M. D.

, 19 (Address) 2327 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cemetery — Date of Burial: Jan 22 1927

20 UNDERTAKER: Mrs Chas G. Bailey — ADDRESS: 1420 Jefferson St

Spec.—1-12-23—M&T—500 Blks.

18192

# HEALTH DEPARTMENT—CITY OF BALTIMORE

10-192 E 18192

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hosp St. 21-29 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Koenig

(a) RESIDENCE No. 606 Wyeth St- ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 7 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year) Jan 18, 1924

7 AGE: Years 2 3 | Months 7 0 | Days 4 3 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Henry J Koenig

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Anna R. Flathman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Mrs. Henry J. Koenig

(Address) 606 Wyeth St-

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 21 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 18, 1927, to Jan 21, 1927.

that I last saw her alive on Jan 21, 1927,

and that death occurred, on the date stated above, at 4 30 p. m.

The CAUSE OF DEATH* was as follows:

Tonsillar - Pharyngeal Diphtheria

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical - Pos. K. L. Culture

(Signed) Myron S. Tull M. D.

1/22, 1927 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. DATE OF BURIAL: Jan 22 1927

20 UNDERTAKER: Zirkler & Zirkler. ADDRESS: 1734 E Eager St

Cor.—12-9-25—A Co.—200 Bks.

Theodore W. Scott.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18193

## CERTIFICATE OF DEATH.

90 E 18193

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hosp (Ward) 14-64

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theodore W. Scott

(a) RESIDENCE NO. Garrett Av 2708 (Ward)

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | white | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 1- 1880

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 46- | 5- | 14 19 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman 186

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Hungary Jan 21, 1927

(State or country)

PARENTS

10 NAME OF FATHER ~~Bob~~ Scott

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Hungary

12 MAIDEN NAME OF MOTHER Milkmich

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Hungary

14 Informant Linda C Scott

(Address) 2708 Stevens

15 FILED JAN 22 1927 19 J. HARRISON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Vasc. dis. heart

Sudden (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Chas Kelly M. D.

(Coroner)

Jan 21, 1927 (Address) 1034 Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem Jan 24 27

Date of Burial

20 UNDERTAKER Jas Jacobs & Son ADDRESS 2173 Park

Cor.—1-12-23—M&T—100 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18194

## CERTIFICATE OF DEATH.

E 18194

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 726 Sargent ST. K3-54 WARD)

2-FULL NAME Cecelia F. Metcalf

(a) RESIDENCE NO 726 Sargent ST. 13 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Widow

If married, widowed or divorced HUSBAND of (or) WIFE of Wm H Metcalf

DATE OF BIRTH (month, day, and year) Nov 22 1876

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 50 | 2 | 27 | |

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) City
(State or country)

10 NAME OF FATHER Geo. Councilman

11 BIRTHPLACE OF FATHER (city or town) Ind
(State or country)

12 MAIDEN NAME OF MOTHER Blaney

13 BIRTHPLACE OF MOTHER (city or town) Ind
(State or country)

Informant Granville Metcalf
(Address) 2 Short St Brooklyn

Filed JAN 2 1927 192 C. HAMPSON JONES, M. D. Registrar

Per

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 19 to 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows: Valvular disease of Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Edward Mosser, M. D.
(Coroner.)

1/20 192 7 (Address) 363 Patterson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem 1/21 192 7

DATE OF BURIAL

20 UNDERTAKER J. J. Moran

ADDRESS 3000 E Baltimore

Spec—12-23-21—E.B.R.S.—400 Bks.

E 18195

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18195

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 614 S. 18th St., 26-37 Ward)

Registered No. 16002

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Laura Gaum

(a) Residence No. 614 S. 18th St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

| 3-SEX. | 4-COLOR OR RACE, | 5-Single, Married, Widowed, or Divorced, (Write the word.) |
|---|---|---|
| F | W. | — |

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Jan. 19-27

7-AGE. ....yrs. ....mos. 7 ds. If LESS than 1 day, ....hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) Child

(c) Name of employer —

9-BIRTHPLACE (city or town) Baltimore (City)
(State or Country),

PARENTS.

10-NAME OF FATHER, William C Gaum

11-BIRTHPLACE OF FATHER (city or town) Tuckahoe Va.
(State or Country),

12-MAIDEN NAME OF MOTHER, Grace M Dorm

13-BIRTHPLACE OF MOTHER (city or town) Clarksburg W Va
(State or Country),

14- (Informant) Mrs. Gaum
(Address) 614 S 18th St

15- Filed ..... 192[illegible] C. HAMPSON JONES, M. D. Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 21-27

17- I HEREBY CERTIFY, That I attended deceased from Jan 19- 19 27 to Jan 21 19 27

that I last saw h[illegible] alive on Jan 21 19 27

and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Protracted Labour

(Duration) ....yrs. ....mos. 6 Hours.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frederick W Heerman M. D.

[illegible] 19 (Address) 7913 E Balto

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

| 19-PLACE OF BURIAL, CREMATION OR REMOVAL. | DATE OF BURIAL. |
|---|---|
| Int Lauriel Cem | 1/21 19 27 |
| 20-UNDERTAKER. J. G Moran | ADDRESS 3000 E Balto |

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 18196 HEALTH DEPARTMENT—CITY OF BALTIMORE E 18196

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 225 N. Dallas St. 6-9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Crist Lewis

(a) RESIDENCE. No. 225 N. Dallas ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Colord

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Lewis

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE Years 27 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED Labor

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

040

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Henry Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Susie St. Johns

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Annie Lewis

(Address) 225 N. Dallas St.

Filed 1-12 1927 C. THOMPSON JONES, M. D.

Per 19 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-15 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 12th, 1927, to Jan 15th, 1927, that I last saw h[illegible] alive on Jan 12th, 1927, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Pulm. Tuberculosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Digital exam.

(Signed) Jacob L. Winner, M. D.

1-15, 1927 (Address) 30 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bolden Church cemetery Baltimore County Va

DATE OF BURIAL Jan 24 1927

20 UNDERTAKER Edward Bryson

ADDRESS 1631 Orleans St

TEX MORQUE.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

18197 E 18197

## CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat St. 26-63 WARD)

2-FULL NAME William Raymond Davis

(a) RESIDENCE NO. Mt Hope Retreat ST., ..... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. 1 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

6 If married, widowed, or divorced (HUSBAND of (or) WIFE of) Single

DATE OF BIRTH (month, day, and year) Dec 7. 1889

| AGE | Years | Months | Days | If LESS than 1 day, brs or min. |
|---|---|---|---|---|
| | 37 | 1 | 14 | |

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Wm S Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lonnie Miles

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Lonnie Davis

(Address) 1155 S. Broadway

Filed 2 1927 C. HAMPSON JONES, M. D.

By ..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 21, 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1926, to Jan 21, 1927, that I last saw him alive on Jan 20, 1927, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Epileptic Convulsions

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Epileptic Psychosis

(duration) 6 yrs. — mos. ds.

18 Where was disease contracted if not at place of death? Mt Hope Retreat

Did an operation precede death? NO Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Physo Exam

(Signed) A. B. Enror, M. D.

1-21, 1927 (Address) Mt. Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery DATE OF BURIAL Jan 24 1927

20 UNDERTAKER George L. Schnauffer & Co ADDRESS 101 Park Ave.

Cor.—12-9-25—A Co.—200 Bks.

Reison Hammond

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18198

# CERTIFICATE OF DEATH.

E 18198

REGISTERED NO. 181-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 115 N Green St., 4-25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jesse Hammond

(a) RESIDENCE NO. 115 N Green St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years: about 53; Months; Days; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Rat Trapper

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER: George Hammond Md

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Md

12 MAIDEN NAME OF MOTHER: Sally Grant

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Md

14 Informant: E. B. Williams

(Address): Woodbury Md

15 Filed: 2 1927 C. HAMPSON JONES, M. D. Registrar

By: [illegible]

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/20 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, Autopsy or Inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(over)

(Signed) Daniel L. Fisher M. D.

(Coroner)

, 19 27 (Address) 333 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 DISPOSITION OF BODY, CREMATION OR REMOVAL: A. A. Co. Date of Burial: Jan 22 1927

20 UNDERTAKER: B. F. Hopping

ADDRESS: Annapolis

Brownsville

Spec.—12-9-25—A Co.—200 Bks.

E 18199

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18199

## CERTIFICATE OF DEATH.

185

16-23

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1013 N Arlington St. Ward)

2-FULL NAME Harriett E Fogle

(a) RESIDENCE NO. 1013 N Arlington St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | W | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Fogle

6 DATE OF BIRTH (month, day, and year) Jan 12 53

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 73 | 0 | 9 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home work

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Miller

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Not Known

14 Informant James A Bamfobell

(Address) 1013 N Arlington Ave

C. HAMPSON JONES, M. D.

Jan 22 1927 — A R K — Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 Jan 21

17 I HEREBY CERTIFY, That I attended deceased from Jan 9 1927, to Jan 21, 1927, that I last saw her alive on Jan 21, 1927, and that death occurred, on the date stated above, at 11.55 P m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) yrs. mos. ds. 1 day 10 hours

CONTRIBUTORY (Secondary) Jaundice

(duration) yrs. mos. ds. Since Jan 9th

18 Where was disease contracted (if not at place of death) Not

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W K Fowler, M. D.

Jan 22, 1927 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hawks Interment Frostburg Md

Date of Burial Jan 24 1927

20 UNDERTAKER W M Routson

ADDRESS 2238 N Howard

Spec.—12-9-25—A Co.—200 Bks.

E 18200

# HEALTH DEPARTMENT—CITY OF BALTIMORE

90

E 18200

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [illegible] St., 75-68 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Pantlow

(a) RESIDENCE NO. 1818 Warwick Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1854

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 73 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER James Raun

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant [illegible] HOSPITALS

(Address) Records

15 Filed [illegible] 19 [illegible] Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 19 1927

17

I HEREBY CERTIFY, That I attended deceased from January 18, 1927, to January 19, 1927, that I last saw h.. alive on January 19, 1927, and that death occurred, on the date stated above, at 8:15 p m.

The CAUSE OF DEATH* was as follows:

Cortical Sclerosis

Chronic Myocarditis & Insufficiency

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? ??? Date of

Was there an autopsy? no

What test confirmed diagnosis? General & Laboratory.

(Signed) D Hooper Smith, M. D.

Jan 20 1927 (Address) [illegible] PARK

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gordonsville Va Date of Burial Jan 23 1927

20 UNDERTAKER Harry H. Witzke ADDRESS 153 W. Lombard

[illegible] HAMPSON JONES [illegible]

JAN 21 1927

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18201

18201

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Joseph's Hospital

CITY OF BALTIMORE: (No. Caroline & Oliver ST., 9-46 WARD) 57

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Addie Smith.

(a) RESIDENCE NO. 1529. E 33rd. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | white | Widow. |

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Dec. 21, 1859

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 67 | 1 | 0 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Pennsylvania. New Castle

10 NAME OF FATHER John Ferry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant Hospital Records.

(Address)

Filed , 19 C. HAMPSON JONES, M. D. Registrar

2 1927 RRS

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 21 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 5 , 1927, to Jan. 21 , 1927, that I last saw her alive on Jan 21. , 1927, and that death occurred, on the date stated above, at 5:25 p. m.

The CAUSE OF DEATH* was as follows:

Diabetes. Mellitus

Chr. Nephritis. Myocarditis.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Gangrene Rt. leg—

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? None

What test confirmed diagnosis? Clinical.

(Signed) A. L. McAnelly M. D.

, 19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL Jan 24 1927

20 UNDERTAKER Harry H Wetzler

ADDRESS 453 W Fayette St

Spec- 12-23-21-E.B.R.S.-400 Bks.

E 18202

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18202

## CERTIFICATE OF DEATH.

129

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1938 Edmondson Ave St., 70-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas H. Llewellyn,

(a) Residence No. 1938 Edmondson Ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 5 mos. 20 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Sarah E. Llewellyn

6-DATE OF BIRTH (month, day and year) Aug. 1. 1851

7-AGE. 75 yrs. 5 mos. 20 ds.

If LESS than 1 day, ... hrs. or. ... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Iron Molder.

(b) General nature of industry, business, or establishment in which employed (or employer) 047

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Harpers Ferry W Va.

PARENTS

10-NAME OF FATHER. Thomas H. Llewellyn

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Wales.

12-MAIDEN NAME OF MOTHER. Elizabeth Ellen Cruzen

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

14- (Informant) Irvin L. Llewellyn.

(Address) 44 S. Catherine St.

15- Filed 2 1927 By C. HAMPSON JONES, M. D. Registrar. Reg'd

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) January 21 27

17- I HEREBY CERTIFY, That I attended deceased from Dec. 17 1926 to Jany 21 1927

that I last saw h. alive on Jany 19 1927

and that death occurred, on the date stated above, at 9.50 a. m.

The CAUSE OF DEATH* was as follows:

Nephritis Chronic

(Duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) — yrs. 4 mos. — ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical methods

(Signed) George C. Shannon M. D

1/21. 1927 (Address) 700 Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Druid Ridge Cemetery

DATE OF BURIAL. Jan 24 1927

20-UNDERTAKER. Harry A. Britzke

ADDRESS 631 W. Lombard St

Spec.—1-10-21—M&T—1500 Blks.

E 18203

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18203

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 707 Appleton St., ST. 16-2129 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachel Bringmann.

(a) RESIDENCE NO. 707 Appleton St., ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Charles Bringmann

6 DATE OF BIRTH (month, day, and year) July 19, 1841

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 85 | 6 | 2 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mamie A. Childs

(Address) 707 Appleton St.

15 Filed 2 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 21 1927.

17

I HEREBY CERTIFY, That I attended deceased from Jan 1, 1927. to Jan. 21. 1927.

that I last saw h alive on Jan. 20. 1927.

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Int. Nephritis.

(duration) — yrs. 8 mos — ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Urine Analysis etc

(Signed) Chas. Sexton, M. D.

1/22 1927 (Address) 888 N. Loudon St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Jan 24 1927

20 UNDERTAKER Harry H. Metzler

ADDRESS 1531 N Fulton Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 18204

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

14 E 18204

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1300 W. Lombard St., ST.: 19-29 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME MARTHA J HAHN

(a) RESIDENCE. NO. 1300 W. Lombard St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late John W. Hahn

6 DATE OF BIRTH (month, day, and year) Feb. 15 1841

| 7 AGE Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|
| 85 | 11 | 5 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER John T. Morgart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unkown

14 Informant W. S. Rice

(Address) 1308 W. Lombard St.

Filed 2 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr. 1925, 19, to Jan 20, 1927, that I last saw her alive on Jan 20, 1927, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

advanced arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Apoplexy (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical signs

(Signed) W. H. Triplett, M. D.

, 19 (Address) 132 W Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Jan 22 19

20 UNDERTAKER: Harry H. Witzke — ADDRESS: 1534 W Lombard St.

Spec.-7-17-26—A Co.—200 Bks.

E 18205

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

45 E 18205

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3041 Walbrook ave St. 15-67 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mc Fadden Taylor

(a) RESIDENCE NO. 3041 Walbrook ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. da.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Taylor

6 DATE OF BIRTH (month, day, and year) April 22 1868

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min.. |
|---|---|---|---|---|
| | 58 | 9 | 0 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Electrical Con

(b) General nature of industry, business, or establishment in whirh employed (or employer) 029

(c) Name of employer

9 BIRTHPLACE (city or town) Wicomico Co (State or country) Md

PARENTS

10 NAME OF FATHER Francis Taylor

11 BIRTHPLACE OF FATHER (City or town) (State or country) Wicomico Co Md

12 MAIDEN NAME OF MOTHER Mary Coombs

13 BIRTHPLACE OF MOTHER (city or town) Johnsontown (State or country) Delaware

14 Informant Mary V. Taylor

(Address) 3041 Walbrook

Filed JAN 23 1927 HAMPSON JONES, M. D. Registrar

Per RK

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 1 1926 to Jan 22 1927.

that I last saw him alive on Jan 21st 1927.

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Intestinal Carcinoma

(duration) 6 yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? Yes Date of 1921

Was there an autopsy? Yes

What test confirmed diagnosis? Laboratory

(Signed) R. L. Scott M. D.

1-22 1927 (Address) 421 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Salisbury Md — Date of Burial Jan 23 1927

20 UNDERTAKER George J Smith — ADDRESS 168 E Hollins

Spec—12-23-21—E.B.R.S.—400 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18206 E 18206

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 100 W. Cross St. 23-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Eschenk

(a) Residence No. 100 W Cross St. St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Henry Eschenk

6-DATE OF BIRTH (month, day and year) July 20th 1851

7-AGE. 75 yrs. 6 mos. 1 ds. If LESS than 1 day, ....hrs. or.... min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS.

10-NAME OF FATHER. John Geiser

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Elizabeth Hammer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

11- (Informant) Henry Eschenk

(Address) 100 W. Cross st

15- DEC 23 1927 E. HAMPSON JONES, M. D.

Per ..... Residence

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan. 21 27

17- I HEREBY CERTIFY, That I attended deceased from Jan. 19 1927 to Jan 21 1927

that I last saw h.. alive on Jan. 21 1927

and that death occurred, on the date stated above, at 7 p.m.

The CAUSE OF DEATH* was as follows:

Appoplexy

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Hemiplegia

(Duration) ....yrs. ....mos. 2 ds.

18-Where was disease contracted if not at place of death? -

Did an operation precede death? NO Date of

Was there an autopsy? NO -

What test confirmed diagnosis? Clinical

(Signed) M. Freilingen M. D.

1/22 1927 (Address) 682 Washington Blvd -

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park — DATE OF BURIAL. Jan 24th 1927

20-UNDERTAKER. Schloman & Son — ADDRESS 1084 Hanover st

Cor.—12-9-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18207

## CERTIFICATE OF DEATH.

90 E 18207

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1923 Hope St St., 9-18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michael [illegible] Hubert

(a) RESIDENCE NO. 1923 Hope St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of XX XXX

6 DATE OF BIRTH (month, day, and year) Mar 5/1869

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 57 | 10 | 15 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md

PARENTS

10 NAME OF FATHER Michael Hubbard

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Eve -------

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Franz Hubbard

(Address) 1813 Ensor St

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

Per

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Valvular Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Weiss, M. D.

(Coroner)

1/22/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery Date of Burial 1/24/1927

20 UNDERTAKER George J. Ruth ADDRESS 1735 Harford Ave

N 23 1927

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18208

90 E 18208

## CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH Hebrew old age Home

City of BALTIMORE: (No. 109 Ann Smith St., 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chipie Handwerger

(a) RESIDENCE NO. 109 Ann Smith St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 30 mos. — ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. 30 mos. — ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rachel

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE — Years: 90 — Months: — — Days: — IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): old

(c) Name of employer

9 BIRTHPLACE (city or town): Poland (State or country)

PARENTS

10 NAME OF FATHER Morris Lemon

11 BIRTHPLACE OF FATHER (City or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant (Address): Mrs Handwerger 109 Ann Smith St

15 Filed JAN 23 1927 19 C. HAMPSON JONES, M. D. Registrar Per ....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 21 19 27

17 I HEREBY CERTIFY, That I attended deceased from Jan. 21st 19 27, to Jan 21st 19 27, that I last saw her alive on Jan. - 19 27, and that death occurred, on the date stated above, at 8 45 P m.

The CAUSE OF DEATH* was as follows:

Coma

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Chronic Valvular dis

(duration) 1 yrs. ....mos. ....ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Nat L. Winner, M. D.

1-22, 1927 (Address) 30 S. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Hebrew Cemetery — Date of Burial: 1/25 1927

20 UNDERTAKER: Sol Levinson & Bro — ADDRESS 1127 E Baltimore

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

18209

## CERTIFICATE OF DEATH.

E 18209

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2909 Rockrose ave ST., 15-58 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Yetta Weinberg

(a) RESIDENCE No. 2909 Rockrose ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., If of foreign birth? 30 yrs. — mos. — ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elias

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years 56 | Months — | Days — | If LESS than 1 day, ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: Samuel Meyer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland.

12 MAIDEN NAME OF MOTHER: Masha Ehrmantz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Elias Weinberg

(Address) 2909 Rockrose Ave

JAN 23 1927

HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 21. 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 16, 1927, to Jan 21, 1927, that I last saw h[illegible] alive on Jan. 21, 1927 and that death occurred, on the date stated above, at 8.15 p. m

The CAUSE OF DEATH* was as follows:

Acute arthritis and diabetes mellitus

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary): Lobar pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Weston W. Va

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) B Kadin, M. D.

1/22/23, 19 (Address) 2306 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rodedale

DATE OF BURIAL: 1/23 19 27

UNDERTAKER: Hol Levinson & Bro

ADDRESS 127 E Balto st

Spec.—12-9-25—A Co.—300 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 18210

E 18210

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Balto City Hospital St. 22-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Riley

(a) RESIDENCE NO. 620 W. Conway St. Ward

(Usual place of abode) (If non-resident give city or town and State)

*Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 27-1913

7 AGE: Years 13 | Months 9 | Days 23 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Chief.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Maryland

(State or country)

PARENTS

10 NAME OF FATHER John A. Riley

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Daisy Riley

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Information Given by Daisy Riley

(Address) 620 Conway St.

15 Date Received JAN 23 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 Jan. 20, 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 17, 1927 to Jan 20, 1927

that I last saw h[illegible] alive on Jan 20, 1927

and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Cor Algae Left

Contributory Lobar Pneumonia Months 5 mos. days

CONTRIBUTORY (Secondary) Endocarditis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted

If not at place of death Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs Only

(Signed) W. Lincoln M. D.

, 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem Date of Burial Jan 23 1927

20 UNDERTAKER: Emmert L. Bradley ADDRESS 1728 Pa Ave

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18211

## CERTIFICATE OF DEATH.

45 E 18211

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5844 W. Preston ST., 17-24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sidonia A Dorsey

(a) RESIDENCE NO. 5844 W. Preston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE: Years 48; Months; Days; If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country): Md. Co. Md.

PARENTS

10 NAME OF FATHER: Abraham Dorsey

11 BIRTHPLACE OF FATHER (City or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Elvira Booze

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Md.

14 Informant: Emma Simms

(Address) 592 W. Preston St.

15 Filed JAN 23 1927 . 19 C. HAMPTON JAMES, M. D. Registrar

Per L K

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 6 1927 to Jan 20 1927

that I last saw h[illegible] alive on Jan 19 1927

and that death occurred, on the date stated above, at 2:05 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Intestines

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. H. Beasley, M. D.

. 19 (Address) 1627 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL 1/25 1927

20 UNDERTAKER: Samuel Kunkel

ADDRESS W Balto

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18212

## CERTIFICATE OF DEATH.

45

E 18212

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE (1019 Seadenhall St. 23-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Oliver Watkins

(a) RESIDENCE NO. 1019 Seadenhall St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Col | Widower |

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Watkins

DATE OF BIRTH (month, day, and year) 1877

| AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 50 | — | — | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Preacher.

(b) General nature of Industry, business, or establishment in which employed (or employer) 018

(c) Name of employer

BIRTHPLACE (city or town) Richmond Co.

(State or country) N. Carolina

10 NAME OF FATHER Calvin Watkins

11 BIRTHPLACE OF FATHER (city or town)

(State or country) N. Carolina

12 MAIDEN NAME OF MOTHER Jones

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) N. Carolina

Informant Callie Watkins

(Address) 1019 Seadenhall

Filed ..... 19..... Registrar .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan - 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec - 30 1926, to Jan - 19, 1927, that I last saw him alive on Jan - 18, 1927, and that death occurred, on the date stated above, at 10 55 m.

The CAUSE OF DEATH* was as follows:

Sarcoma of mesentery

(duration) — yrs. 8 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Ex plorotary Laparotomy Date of at this

Was there an autopsy? no

What test confirmed diagnosis? Johns Hopkins Hosp

(Signed) Dan Grumbine, M. D.

1/28, 1927 (Address) 122 E Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Date of Burial 1/23 1927

UNDERTAKER C. HAMPSON JONES, M. D. ADDRESS 58 Bolton

JAN 23 1927

Permit

Registrar

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18213

## CERTIFICATE OF DEATH.

46

E 18213

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 627 W. Lafayette Av. St., 17-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia B Schultz

(a) RESIDENCE NO. 627 W Lafayette Av. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Schultz

6 DATE OF BIRTH (month, day, and year) Nov. 21 1869

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 57 | 2 | 1 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balt

(State or country) Md.

PARENTS

10 NAME OF FATHER Bernard Bayline

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Corena Crosby

(Address) 627 W Lafayette Av.

Filed 2 3 1927 C. HAMPSON JONES, M. D.

By K K Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22 1927

17 I HEREBY CERTIFY, That I attended deceased from May 15 1926, to Jan 22 1927, that I last saw h.. alive on Jan 21, 1927, and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C William Frey, M. D.

1/22, 1927 (Address) 1720 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Date of Burial Jan 25 1927

20 UNDERTAKER W M Corkran & Son ADDRESS Baltimore

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18214

## CERTIFICATE OF DEATH.

REGISTERED NO. E 18214

1-PLACE OF DEATH

City of BALTIMORE: (No. 1130 Brewer · St. 17-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosie Owens

(a) RESIDENCE NO. 1130 Brewer St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | C | M |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1890

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 37 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Va

PARENTS

10 NAME OF FATHER Geo. Aiken

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Rosa Aiken

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Fred Owens

(Address) 1130 Brewer St

Filed JAN 23 1927 E. HAMPSON JONES, M. D.

Per Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 24 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hardening of the arteries

(duration) 1 yrs. mos. ds.

(Signed) J. T. Hennessy M. D.

(Coroner)

Jan. 23 1927 (Address) 2803 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon County Date of Burial Jan. 28 1927

20 UNDERTAKER Robert F. Nelson ADDRESS 1515 W. Baltimore St

Spec.—12-9-25—A Co.—200 Bks.

E 18215

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1022 W. Lombard St., 18-29 Ward)

2-FULL NAME Elizabeth M. Lindenmeyer

(a) RESIDENCE NO. 1022 W. Lombard St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. 2 mos. 16 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

29 E 18215

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | White | widowed |

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Robert Lindenmeyer

6 DATE OF BIRTH (month, day, and year)
November 7. 1876

| 7 AGE | Years | Months | Days | IF LESS than 1 day ... hrs. or ... min. |
|---|---|---|---|---|
| | 50 | 2 | 16 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) Keeping house
(c) Name of employer —

9 BIRTHPLACE (city or town)
(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Fred. R. Schweikert

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Anna Wagner

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Pauline Forstmann
(Address) 1022 W Lombard St.

15 Filed ... 1927 Registrar
By —

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 21 1927

17
I HEREBY CERTIFY, That I attended deceased from Oct 10, 1926, to Jan 21, 1927, that I last saw h.. alive on Jan 21, 1927, and that death occurred, on the date stated above, at 10.30 A m.

The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) ~~Intermittent nephritis~~ over 3 months (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted
If not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical tests
(Signed) Henry E. O'Rourke M. D.
1-21, 1927 (Address) 1203 W Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery Date of Burial 1/24/ 1927.

20 UNDERTAKER John F. Gowan & Son ADDRESS 901 W. Lombard St.

C. HAMPSON JONES, M. D.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18216

## CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH West Baltimore General Hospital

CITY OF BALTIMORE: (No. Raymond Dukeland ST., 27 56 WARD)

REGISTERED NO. E 18216

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Whitton

(a) RESIDENCE NO. 303 Spalding Ave ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? 27 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ada Whitton

6 DATE OF BIRTH (month, day, and year): March 15 1896

7 AGE — Years: 30 — Months: 10 — Days: 7 — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Printer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

063

9 BIRTHPLACE (city or town) (State or country): Russia

10 NAME OF FATHER: Ruben Witton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Sarah Sheftis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

Informant: Ada Whitton
(Address) 303 Spalding ave

Filed 3-1927 .19 C. HAMPSON JONES, M. D.
Per ..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/22 19 27

17 I HEREBY CERTIFY, That I attended deceased from 1/19 .19 27 to 1/22 .19 27
that I last saw him alive on 1/22 .19 27
and that death occurred, on the date stated above, at 11.10 A .m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary): Acute cardiac dilatation (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Benjamin Miller M. D.

.19 (Address) W. B. G. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Herman Lunn — DATE OF BURIAL: 1/23 19 27

20 UNDERTAKER: Jack Lewis — ADDRESS: 1437 E Lord st

Spec.—12 9 25—A Co.—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18217

## CERTIFICATE OF DEATH.

101-001 E 18217

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1415 Poplar Grove St., 16-69 Ward)

2-FULL NAME Emilie Momenthy

(a) RESIDENCE NO. 1415 Poplar Grove St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? 72 yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: Female White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Bruno Momenthy

6 DATE OF BIRTH (month, day, and year): Nov. 7 - 1840

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 86 | 2 | 14 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Own

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Germany

PARENTS

10 NAME OF FATHER: Frederick Bissy

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Miller

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: Ida Momenthy

(Address) 1415 Poplar Grove st.

15 Filed C. HAMPSON JONES, M. D. Registrar

2 3 1927 By R.P.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 Jan. 21.

17

I HEREBY CERTIFY, That I attended deceased from Jan 17 1927 to Jan 21, 1927, that I last saw her alive on Jan 20, 1927, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. 4 mos. 6 ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart (duration) ✓ yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? Place of Death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys Examination

(Signed) John A. Treland M. D.

1/24, 1927 (Address) 1219 Poplar Grove St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Date of Burial: Jan 24. 1927

20 UNDERTAKER: Mrs John H. Tembel & Son ADDRESS: 801 W. Fayette St

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 18218
1-PLACE OF DEATH

52 E 18218
REGISTERED NO.

City of BALTIMORE: (No. 813 Willow St. St. 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bridget Hogan

(a) RESIDENCE NO. 813 Willow St, St. Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | White | Married. |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Hogan.

6 DATE OF BIRTH (month, day, and year): Unknown 1849.

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 78 | — | — | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town):
(State or country) England

PARENTS
10 NAME OF FATHER: Thomas Quinn
11 BIRTHPLACE OF FATHER (city or town):
(State or country) Ireland
12 MAIDEN NAME OF MOTHER: Unknown
13 BIRTHPLACE OF MOTHER (city or town):
(State or country) Unknown

14 Informant: Thomas Hogan
(Address) 813 Willow St.

15 Filed ..., 19...

23 1927 C. H. JONES, M. D. Registrar of Vital Statistics.
By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19
January 22nd. 1927.

17 I HEREBY CERTIFY, That I attended deceased from Dec. 18, 1926, to Jan. 22, 1927, that I last saw her alive on Jan 21, 1927, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:
Cardiac dilatation

(duration) Not ascertained yrs. mos. ds.
CONTRIBUTORY (Secondary) Rheumatism
(duration) Not ascertained yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Examination
(Signed) Benj. D. Hanson, M. D.
1/22/1927 (Address) 216 N. Caroline st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery. Date of Burial: 1/25 19 27

20 UNDERTAKER: Chas. R. Grace & Son ADDRESS 118 W. Mt. Royal Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

E 18219

# HEALTH DEPARTMENT—CITY OF BALTIMORE

11-007

## CERTIFICATE OF DEATH.

E 18219

1-PLACE OF DEATH

City of BALTIMORE: (No. 1104 Stockton St., 16-23 Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Walter Coles

(a) Residence No. 1104 N Stockton St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) June - 1923

7-AGE, 3 yrs. 7 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Horace Coles

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Mary Stokes

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Philada.

14- (Informant) Mary Coles

(Address) 1104 Stockton St.

15- Filed JAN 23 1927 C. HAMPSON JONES, M. D. Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 1-20-27

17- I HEREBY CERTIFY, That I attended deceased from Jan 17, 1927, to Jan 20, 1927, that I last saw h[illegible] alive on Jan 20, 1927, and that death occurred, on the date stated above, at 6:14 m.

The CAUSE OF DEATH* was as follows:

Acute nephritis

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Acute tuberculosis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. Cook, M. D.

, 19 (Address) 655 W Lee St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt Auburn Cemetery DATE OF BURIAL, Jan 23, 1927

20-UNDERTAKER, Jos. T. H. Rochester ADDRESS 1403 Jefferson St.

Spec.—1-12-23—M&T—500 Bks.

19863 1

E 18220

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

131 E 18220

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ) ST. 10-14 WARD)

2-FULL NAME John Vail

(a) RESIDENCE NO. 721 E Preston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced. (write the word): married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6b DATE OF BIRTH (month, day, and year) unknown

7 AGE: Years 50; Months —; Days —; If LESS than 1 day, hrs. or min. —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): O'Donnell

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

10 NAME OF FATHER: Horatio Vail

11 BIRTHPLACE OF FATHER (city or town) (State or country): New York

12 MAIDEN NAME OF MOTHER: Anna Metcalfe

13 BIRTHPLACE OF MOTHER (city or town) (State or country): New York

PARENTS

14 Informant: Records (Address) JOHNS HOPKINS HOSPITAL

Filed JAN 23 1927 C. HAMPSON JONES, M. D. Registrar

Per —

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 24, 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 27, 1926, to Jan 24, 1927

that I last saw him alive on Jan 24, 1927,

and that death occurred, on the date stated above, at 6 10 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Failure

Pyelonephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of Jan 1927

Was there an autopsy? Yes

What test confirmed diagnosis? Gen Mort. Ex

(Signed) F. W. Schacht, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount — DATE OF BURIAL 1/24/27

20 UNDERTAKER: Joseph Ahern — ADDRESS 22 Bo

Spec.—1-12-23—M&T 2500 Blks.

E 1903
E 18221

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129 E 18221

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7-9 WARD)

2-FULL NAME James P. Cowan

(a) RESIDENCE NO. Delway N. Car ST., ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 14 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: col

5 Single, Married, Widowed, or Divorced, (write the word): married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE: 58 Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Preacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa -

PARENTS

10 NAME OF FATHER William Cowan

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C -

12 MAIDEN NAME OF ~~Mother~~ Fullerman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Ricardo

(Address) JOHNS HOPKINS HOSPITAL

Filed JAN 23 1927 HAMPSON JONES, M. D. Registrar

By R.M.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 21 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 7, 1927, to Jan. 21, 1927.

that I last saw h.. alive on Jan. 21, 1927

and that death occurred, on the date stated above, at 3 15 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Chronic Nephritis

Hypertension

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

Cerebral Hemorrhage (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Milton Sherry, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Clinton & | DATE OF BURIAL 1/25/27

UNDERTAKER Joseph Adams | ADDRESS

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18222

## CERTIFICATE OF DEATH.

28-64 ×3

E 18222 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3704 Norwood Ave ST., 28 WARD)

2-FULL NAME Edward Thomas

(a) RESIDENCE NO. 3704 Norwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Thomas

6b DATE OF BIRTH (month, day, and year) Jan 1 1853

7 AGE Years 74 Months Days 22 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Motorcar

(b) General nature of industry, business, or establishment in which employed (or employer) 0/4

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Phila Pa

10 NAME OF FATHER Fredk Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Bolton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Phila Pa

14 Information Given By Mrs Edna M Ahrens

(Address) 3704 Norwood Ave

15 Filed 2 3 1927 19 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1926, to Jan 22, 1927, that I last saw h[illegible] alive on Jan 21st, 1927, and that death occurred, on the date stated above, at 1 15 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rt tonsil tongue and floor of mouth

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) asthenia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Atlantic City

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Xray

(Signed) C. Hampson Jones, M. D.

(Address) 2802 Roslyn Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Phila Pa — DATE OF BURIAL 1/24 1927

20 UNDERTAKER Stanley Finky Fulton — ADDRESS Fayette

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18223

## CERTIFICATE OF DEATH.

10-002 E 18223

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST., 16-67 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy H. Warfield

(a) RESIDENCE NO. 3012 Annual Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. 5 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 15, 1916

7 AGE: Years 10 Months 5 Days 4 If LESS than 1 day, ... hrs or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

10 NAME OF FATHER: J. H. Warfield

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Helen Rupp

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto.

PARENTS

14 Informant: Mrs. J. H. Warfield

(Address) 3012 Annual Ave

FILED JAN 23 1927 HAMPSON JONES, M. D.

By R.H. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 13, 1927, to Jan 22, 1927, that I last saw h[illegible] alive on Jan 22, 1927, and that death occurred, on the date stated above, at 1.45 a m.

The CAUSE OF DEATH* was as follows:

Tonsillar + Pharyngeal Diphtheria

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Pos. N.L. Cult.

(Signed) Myron G. Tull, M. D.

1/22, 1927 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Jan 23 1927

20 UNDERTAKER: Wm J. Gruckner & Sons — ADDRESS: N. Y. Ave

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18224

## CERTIFICATE OF DEATH.

100-001

E 18224

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1606 Lancaster ST. 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Milred Gutowski,

(a) RESIDENCE NO. 1606 Lancaster ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept., 26/26.

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 0 | 3 | 26 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) MD.

PARENTS

10 NAME OF FATHER Casimir Gutowski,

11 BIRTHPLACE OF FATHER (city or town) Baltimore,
(State or country) MD.

12 MAIDEN NAME OF MOTHER Stella Stilo,

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland,

14 Informant Casimir Gutowski,
(Address) 1606 Lancaster Street

15 Filed JAN 23 1927 C. HAMPSON JONES, M. D.
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 19th, 1927, to Jan. 22nd, 1927,

that I last saw her alive on Jan. 21st, 1927,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam.
A. F. Rees

(Signed) , M. D.

Jan 22nd, 1927 (Address) 24 S. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus.

DATE OF BURIAL Jan 27 1927

20 UNDERTAKER M. F. Sadow Co.

ADDRESS 905 Fleet

Spec.—12-9-25—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18225 E 18225

## CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

City of BALTIMORE: (No.) 4715 Locust Ave St. 27-48 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Adams Hunt

(a) RESIDENCE NO. 4715 Locust Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. 11 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: wife of Edward L. Hunt

6 DATE OF BIRTH (month, day, and year): Feb 3 1875

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 51 | 11 | 18 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore, Md

(State or country)

PARENTS

10 NAME OF FATHER: William Adams

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Baltimore, Md

12 MAIDEN NAME OF MOTHER: Margaret Knight

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Baltimore Md

14 Informant: Edward L. Hunt Husband

(Address) 4715 Locust Ave

15 Filed HAMPSON JONES, M. D.

DEC 23 1927 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Jan 21st 1927

17 I HEREBY CERTIFY, That I attended deceased from May 1st 1926, to Jan 21st 1927,

that I last saw h alive on Jan 21st, 1927,

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows: Chronic Valvular Endocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Bronchopneumonia

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Laboratory

(Signed) L. L. Gordy, M. D.

(Address) 4218 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cem Date of Burial 1/24 1927

20 UNDERTAKER: Leonard J. Rueck ADDRESS Govans

Spec.—1-10-21—M&T—1500 Bks.

E 18226 HEALTH DEPARTMENT—CITY OF BALTIMORE 2007 18226.

E 18226

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Maryland General Hospital 58 REGISTERED NO.

CITY OF BALTIMORE: (No. 17-19 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Teresa Davis

(a) RESIDENCE NO. 1705 No. Calvert St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Mr. Robert Davis

6 DATE OF BIRTH (month, day, and year) Mar 2, 1897.

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 29 | 10 | 19 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wood Island.

PARENTS

10 NAME OF FATHER Patrick Doherty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret McCaul

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Robt. Davis 1705 E. Calvert St

NOV 23 1927 C. HAMPSON JONES, M. D. Registrar

Per

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 21 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 14, 1927, to Jan 21, 1927,

that I last saw h[illegible] alive on Jan 21, 1927,

and that death occurred, on the date stated above, at 3:25 P m.

The CAUSE OF DEATH* was as follows:

Cardiac Disease

about 9 months (duration)

CONTRIBUTORY (Secondary) Pneumonia (duration) 2 days

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of Jan 20, 1927

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno A Young M. D.

1927 (Address) 1 W Mt Vernon Pl

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 1/24 1927

20 UNDERTAKER J. A. Moran

ADDRESS 2116 E Baltimore

Spec.-7-17-26—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

18227

# CERTIFICATE OF DEATH

**E 18227** 1-PLACE OF DEATH

90

**E 18227** REGISTERED NO.

City of BALTIMORE: (No. 1265 Riverside St. 24-33 W.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary G. Butler

(a) RESIDENCE NO. 1265 Riverside St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 Color or Race White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. Butler

6 DATE OF BIRTH (month, day, and year) Jan 21-1864

7 AGE Years 63 Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ind.

(State or country)

PARENTS

10 NAME OF FATHER Lusick

11 BIRTHPLACE OF FATHER (City or town) Ind.

(State or country)

12 MAIDEN NAME OF MOTHER don't know

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Florence Hayne

(Address) 1265 Riverside Ave

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

N 23 1927 Per

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 21 19 27.

17 I HEREBY CERTIFY, That I attended deceased from Jan 13, 19 27, to Jan 21, 19 27.

That I last saw h[illegible] alive on Jan 27, 19 27.

and that death occurred, on the date stated above, at 11:45 P.M.

The CAUSE OF DEATH* was as follows:

Terminal pneumonia.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr Myocarditis & Bronchitis.

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) John A. Schmidt, M. D.

19 (Address) 1337 St Charles Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bryantown Md. Date of Burial 1/24 1927

20 UNDERTAKER J. A. Groan ADDRESS 300 E. Baltor

Spec.—1-10-21—M&T—1500 lbks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18228

## CERTIFICATE OF DEATH.

100-001 18228

E 18228 REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. Baltimore, Md. ST. 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Wagner

(a) RESIDENCE NO. 2406 St. Paul St ST., 12 WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 2 mos. 26 ds. How long in U. S., if of foreign birth? 38 yrs. 2 mos. 26 ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | ~~Married~~ Separated |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mamie H. Wagner

6 DATE OF BIRTH (month, day, and year) Sep. 26-1888

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 38 | 2 | 26 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bond Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Bond salesman 066

(c) Name of employer Stambleton & Co Balto.

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Frank Wagner,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rose Brecht,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Baltimore City Hospital

(Address) Baltimore, Md.

15 Filed JAN 23 1927 19 HAMPSON JONES, M. D. Registrar

For RR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-21- 19 27

17 I HEREBY CERTIFY, That I attended deceased from 1-17 , 19 27 , to 1-21-27 , 19 , that I last saw h in alive on 1-21- , 19 27 , and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Terminal Bronchopneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Alcoholic Psychosis Acute Alcoholic Delirium

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? ~~Yes~~ No.

What test confirmed diagnosis?

(Signed) Harry Goodman M. D.

1/22/27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL Jan 24 1927

20 UNDERTAKER STEWART & MOWEN COMPANY

(WILLIAM F. MOWEN, Successor)

ADDRESS 108 W. NORTH AVE.

pec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

18229.

E 18229

## CERTIFICATE OF DEATH.

90

REGISTERED NO. E 18229

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST. 2863 WARD)

2-FULL NAME Rebecca McHenry

(a) RESIDENCE NO. Mt Hope Retreat ST., 28th WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? Unknown yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced — HUSBAND of (or) WIFE of: Dr McHenry

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years: about 85 | Months: — | Days: — | If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework -

(b) General nature of industry, business, or establishment in which employed (or employer): 11

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Not Known

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Records of Mt Hope (Address)

15 JAN 23 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 23rd 1927

17 I HEREBY CERTIFY, That I attended deceased from July 22nd, 1926, to Jan 23rd, 1927, that I last saw her alive on Jan 22nd, 1927, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis - Post Arterio-Sclerosis -

Unknown Came from Bay View with no History (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Senile Psychosis - Unknown (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Baltimore Md -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Hennery, M. D.

Jan 23rd 1927 (Address) Mt Hope Retreat -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cemetery — DATE OF BURIAL: Jany. 24 1927

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor) — ADDRESS: 108 W. NORTH AVE.

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18230

## CERTIFICATE OF DEATH

x 49

E 18230

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. University Hospital St. 4-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Kirby Jr.

(a) RESIDENCE NO. Linden Ave. St. Ward Md

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos 22 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Widowed |

5a If married, widowed, or divorced HUSBAND of ([redacted]) of Sadie A. Cockey

6 DATE OF BIRTH (month, day, and year) [illegible] ?

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min.. |
|---|---|---|---|---|
| | 68 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Nicholas B. Kirby

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Fannie Hopkins

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant J. Ed. Kirby Jr.

(Address) Linthicum Heights Md.

15 2 3 1927 C. HAMPSON JONES, M. D. Registrar

Per [illegible]

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 23, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1, 19 27, to Jan. 23, 19 27

that I last saw h[illegible] alive on Jan. 22, 19 27

and that death occurred, on the date stated above, at 12:15 A.m.

The CAUSE OF DEATH* was as follows: Cancerous of prostate gland

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Cytoscopic Exam.

(Signed) Jacob Reitman, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Centreville, Md. Date of Burial 1/24 1927

20 UNDERTAKER E. J. Fanning Inc - 1938 E. Lafayette Ave. ADDRESS

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

**E 18231**

## CERTIFICATE OF DEATH.

**E 18231**

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 534 Lambert St. 17th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Hall

(a) RESIDENCE NO. 534 Lambert St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? 40 yrs. ____ mos. ____ ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William T. Hall

6 DATE OF BIRTH (month, day, and year): July 12 1881

7 AGE: Years 45 | Months 6 | Days 9 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Own

(c) Name of employer

9 BIRTHPLACE (city or town): Belair

(State or country): Md

PARENTS

10 NAME OF FATHER: Joseph Hall

11 BIRTHPLACE OF FATHER (city or town): Belair

(State or country): Md

12 MAIDEN NAME OF MOTHER: Clara Wilmer

13 BIRTHPLACE OF MOTHER (city or town): Belair

(State or country): Md

14 Informant: Mamie Barney

(Address): 534 Lambert St.

Filed 1-24 1927

C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: Jan 21 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 16, 1927, to Jan 21, 1927, that I last saw h.. alive on Jan 21, 1927 and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ____ yrs. ____ mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

1-23 1927 (Address) 1126 Druid Hill

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel — Date of Burial: Jan 24 27

20 UNDERTAKER: John H. Soden — ADDRESS 1027 Druid Hill

Spec.—12-9-25—A Co.—200 Pks.

E 18232

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 E 18232

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. 20-70 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Cooper

(a) RESIDENCE NO. 3058 Stafford st. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1891

7 AGE: Years 35; Months; Days; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Millworker

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town)

(State or country): Maryland

PARENTS

10 NAME OF FATHER: John W. Cooper

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Maryland

12 MAIDEN NAME OF MOTHER: Ruth Berber

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Maryland

14 Informant: Hospital Records

(Address)

15 Filed 2 4 1927, 19 C. HAMILTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: January 21, 1927

17 I HEREBY CERTIFY, That I attended deceased from July 29, 19 26, to January 21, 19 27,

that I last saw him alive on January 21, 19 27,

and that death occurred, on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Tuberculosis Peritonitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. E. Gatch, M. D.

1-21-27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Date of Burial: Greenmount Cem. Balto Co Jan 24 27

20 UNDERTAKER: W. C. Brooks ADDRESS: Sparks Md

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18233

## CERTIFICATE OF DEATH.

101-001

E 18233

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3V-0V Grantley ST., Ashburton 15-62 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William A. James

(a) RESIDENCE No. 3V-0V Grantley ST., ..... WARD .....
(Usual place of abode) about
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | white | married |

5a If married, widowed, or divorced HUSBAND of or) WIFE of Julia C. James

6 DATE OF BIRTH (month, day, and year) Feby 10 1859

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs or ..... min. |
|---|---|---|---|---|
| | 67 | 11 | 13 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manufacturing Lumberman

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) Ebensburg Penna
(State or country)

PARENTS

10 NAME OF FATHER William James

11 BIRTHPLACE OF FATHER (city or town) England
(State or country)

12 MAIDEN NAME OF MOTHER Mary Evans

13 BIRTHPLACE OF MOTHER (city or town) Penna
(State or country)

14 Informant Julia C. James
(Address) 3V-0V Grantley St.

15 Filed JAN 24 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 19, 1927, to Jan 23, 1927, that I last saw h-in alive on Jan 22, 1927, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) ... yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Lobar pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) W B Tuttle, M. D.

Jan 23, 1927 (Address) 2220 Garrison ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Kane Penna — DATE OF BURIAL Jan 24 1927

20 UNDERTAKER Chas. G. Black — ADDRESS 742 W Fayette

Spec.—6-9-19—H. P. Co.—1000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18234
1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

31

E 18234
REGISTERED NO.

CITY OF BALTIMORE: (No. Forest Pk Ave. Hillsdale 28-65 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Russell Walter Jones.

(a) RESIDENCE. No. Forest Park Ave ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 27 1902

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 24 | 2 | 25 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Union Railways

9 BIRTHPLACE (city or town) Balto Co
(State or country) Md.

PARENTS

10 NAME OF FATHER William H. Jones

11 BIRTHPLACE OF FATHER (city or town) Balto Co
(State or country) Md.

12 MAIDEN NAME OF MOTHER Minnie L. Seddicord

13 BIRTHPLACE OF MOTHER (city or town) Balto Co
(State or country) Md.

14 Informant Walter Seddicord
(Address) Hillsdale Md.

15 Filed JAN 24 1927 C. HAMPSON JONES, M. D.
Registrar
Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 21 1927

17 I HEREBY CERTIFY, That I attended deceased from July . 1926. to Jan 21 . 1927.
that I last saw him alive on Jan 20 . 1927.
and that death occurred, on the date stated above, at 3 2 m.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Inoculation T. Ray

(Signed) C. C. Cummin . M. D.

(Address) 4208 Liberty Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Lorraine Park Cem | Jan 26 '27 |

20 UNDERTAKER Joseph B Cook
ADDRESS 1003 N. Balto St

Spec.—1-12-23—M&T—500 Blks.

E 18235

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

74001

E 18235

REGISTERED NO.

1-PLACE OF DEATH — Bloomfield

CITY OF BALTIMORE: (No.) Hall Ave. (ST.) (WARD) 35-12

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George I. Buppert

(a) RESIDENCE NO. Hall Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widowed |

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Buppert

7 DATE OF BIRTH (month, day, and year) March 3 1854

| AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 72 | 10 | 19 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Baker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Woodlawn Md.

10 NAME OF FATHER Mr. Buppert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Woodlawn Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

PARENTS

14 Informant: Franklin H. Buppert

(Address) Bloomfield, Md.

15 Filed JAN 24 1927 19 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January, 22 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1926, to Jan 22 1927

that I last saw h alive on Jan 22 1927

and that death occurred, on the date stated above, at 3.15 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clifford Grain, M. D.

1/23, 1927 (Address) 1227 Washington B'lvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Jan 25 1927

UNDERTAKER: Joseph B Cook

ADDRESS: 1003 N Calvert

Spec.—12-9-25—A Co.—200 Bks.

# E 18236 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

51 E 18236

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospital St. 17 76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hesley Tyler

(a) RESIDENCE NO. 714 Edmondson ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): ?

7 AGE: Years 43 — Months — Days — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town): Va

(State or country)

PARENTS

10 NAME OF FATHER: Geo Whele

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Va

12 MAIDEN NAME OF MOTHER: Mahlela

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Va

14 Informant: Mrs. Stacy

(Address): Alexandria Va.

JAN 24 1927 C. HAMPSON JONES, M. D. Registrar

Per R.E.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 Jan 20,

17 I HEREBY CERTIFY, That I attended deceased from Jan 15 1927, to Jan. 20, 1927,

that I last saw ... alive on Jan 20, 1927,

and that death occurred, on the date stated above, at 3.35 p m.

The CAUSE OF DEATH was as follows:

Diabetes Ulcer Right foot.

(duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) Lenual Bronchopneumonia

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Laboratory

(Signed) C. Hampson Jones M. D.

, 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Alexander, Va. Date of Burial 1/24/1927

20 UNDERTAKER: Mrs. Geo. A. Holland ADDRESS 1631 Druid Hill

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

74 E 18237 001

E 18237.

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2231 E. Fayette St. 6-10 Ward)

2-FULL NAME Michael Wermuth

(a) RESIDENCE NO. 2231 E. Fayette St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? 61 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed or divorced HUSBAND of (or ~~WIFE~~) of: Josephine Wermuth

6 DATE OF BIRTH (month, day, and year): Apr 20/1854

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 72 | 9 | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Germany

(State or country)

PARENTS

10 NAME OF FATHER: Conrad Wermuth

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Germany

14 Informant: Josephine Wermuth

(Address): 2231 E. Fayette St.

15 Filed ..... 19 .....

C. HAMPSON JONES, M. D.

Per ..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/20/27

17 I HEREBY CERTIFY, That I attended deceased from April 5 1926 to Jan. 20 1927, that I last saw him alive on Jan. 19 1927, and that death occurred, on the date stated above, at 9:45 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. 21 ds.

CONTRIBUTORY (Secondary) Hemiplegia - due to previous cerebral Hemorrhage.

(duration) ..... yrs. 8½ mos. ..... ds.

18 Where was disease contracted?

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Henry B. Thay, M. D.

1/21, 1927 (Address) 2504 Pratt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Pk — Date of Burial: 1/24 1927

20 UNDERTAKER: Philip Herwig — ADDRESS 2016 Orleans

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

**E 18238**

**CERTIFICATE OF DEATH.**

**E 18238**

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospital 5-8 Ward)

2-FULL NAME Mozelle Randall

(a) RESIDENCE NO. 8 N Caroline St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3 SEX: F

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1903

7 AGE: Years 23 (24) | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Launderer

(b) General nature of industry, business, or establishment in which employed (or employer): 04

(c) Name of employer

9 BIRTHPLACE (city or town): Va

(State or country)

PARENTS

10 NAME OF FATHER: James Cosby

11 BIRTHPLACE OF FATHER (city or town): Va

(State or country)

12 MAIDEN NAME OF MOTHER: Alice Roberts

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Va

14 Informant: Bernice Scott

(Address) 8 N. Caroline St.

Date: JAN 24 1927

THAMPSON JONES, M. D.

For: Registrar

**MEDICAL CERTIFICATE OF DEATH**

16 DATE OF DEATH (month, day, and year): Jan. 22. 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 18. 1926, to Jan. 22, 1927.

that I last saw h 8 alive on Jan 22, 1927

and that death occurred, on the date stated above, at 6 02 M.

The CAUSE OF DEATH* was as follows: Abscess 2 abdominal wall with Secondary Septicemia Cystitis

(duration) mos. ds.

CONTRIBUTORY (Secondary): Labor Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Sign

(Signed) W Bagwell M. D.

, 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Date of Burial: Cedar Cemetery Jan. 26 1927

20 UNDERTAKER: Chas. H. Johnson. ADDRESS: 446 N. Carrollton

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18239

E 18239

## CERTIFICATE OF DEATH.

14-201

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 314 S. Duncan St., 1st (Ward) 3

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Appel

(a) RESIDENCE NO. 314 S Duncan ST. 1st WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 7 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~: Mary Appel

6 DATE OF BIRTH (month, day, and year): April 29th 1851

7 AGE — Years: 69 — Months: 8 — Days: 25 — If LESS than 1 day, ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cigar Maker

(b) General nature of industry, business, or establishment in which employed (or employer): 017

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore City

PARENTS

10 NAME OF FATHER: Conrad Appel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Vogel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Mary Appel

(Address): 314 S Duncan St

15 Filed 1-24-1927 C. HARRISON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 23rd 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan 1 1926 to Jan 23 1927.

that I last saw h/ll alive on Jan 22 1927

and that death occurred, on the date stated above, at 12.40 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

from ~~Influenza~~ (duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Thurston, M. D.

1-24-1927 (Address) 3150 Sanford St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cem — DATE OF BURIAL: Jan 26 1927

20 UNDERTAKER: Peter Nicolaus 2913 Eastern Ave — ADDRESS

Spec.—1-12-23—M&T—500 Bks.

19387

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18240

## CERTIFICATE OF DEATH.

90 E 18240

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ) ST., 947 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William F. Wernsing

(a) RESIDENCE NO. 2727 Flemwick Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Susan Wernsing

7 DATE OF BIRTH (month, day, and year) Oct. 28, 1875

8 AGE: Years 51 | Months — 2 | Days 25 | If LESS than 1 day, hrs. or min.

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk in Bank

(b) General nature of industry, business, or establishment in which employed (or employer) 009

(c) Name of employer Continental Tr. Co.

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER John Wernsing

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Cecilia Stalling

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

Filed JAN 24 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 9, 1927, to Jan. 23, 1927, that I last saw h alive on Jan. 23, 1927, and that death occurred, on the date stated above, at 12 36 A-m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia bilateral

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Chronic myocarditis

(duration) yrs. 10 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Ye, Date of Jan 22-27

Was there an autopsy? Yes, by surgeons

What test confirmed diagnosis? Phy. Exam

(Signed) Warfield Mynor, M. D.

, 19 (Address) ? H A

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: 1/26, 1927

20 UNDERTAKER: Henry U. Mears

ADDRESS: 805 N. Calvert

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18241

100-001

## CERTIFICATE OF DEATH.

E 18241

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 708 S. Hanover ST. 22-31 WARD)

2-FULL NAME Robert Lee White

(a) RESIDENCE No. 708 S. Hanover ST., 22 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | Colored | Single |

a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) 1/17/27

| AGE | Years | Months | Days | If LESS than 1 day.....hrs. or ....min. |
|---|---|---|---|---|
| | | | 5 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Isaac White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Franklin Co. Va.

12 MAIDEN NAME OF MOTHER Odel Louise Chandler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Hampton Va

Informant Sarah White

(Address) 708 Hanover St

Filed 1-24 1927 HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/22 1927

17

I HEREBY CERTIFY, That I attended deceased from 1/17, 1927, to 1/22, 1927,

that I last saw him alive on 1/22, 1927,

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia without any infections disease

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) W. W. Bishop, M. D.

, 19 (Address) 709 Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion — DATE OF BURIAL Jan 24 1927

20 UNDERTAKER R. L. Parham 1216 N. — ADDRESS Sharp St

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18242

## CERTIFICATE OF DEATH.

E 18242
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE—No. 1432 Druid ST. 15-21 WARD)

2-FULL NAME Anna M. Cline

(a) RESIDENCE No. 1432 Druid ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | C | M |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank McCline

6 DATE OF BIRTH (month, day, and year) 1818

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs. or min. |
|---|---|---|---|---|
| | 48 | 1879 | 1 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) S C

PARENTS

10 NAME OF FATHER Jim Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) S C

12 MAIDEN NAME OF MOTHER May Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S C

14 Informant Rosa Reid
(Address) Fairfield Ind

15 4 1927

16 C. HAMPSON JONES, M. D. Registrar
Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/21 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 2 1926, to Jan 21 1927
that I last saw h[illegible]ive on 1/20/27, 19
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Bright's Disease

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. H. Guthrie, M. D.

, 19 (Address) 1343 Druid

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL Jan 24 1927

20 UNDERTAKER Robert Whitelock ADDRESS 1515 McElderry St

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

**18243**

## CERTIFICATE OF DEATH.

128 V

**E 18243**

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 214 N Mount St., 19-27 Ward)

2-FULL NAME David Thompson

(a) RESIDENCE NO. 214 N. Mount St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col'd

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 3 y | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Md.

(State or country)

PARENTS

10 NAME OF FATHER: John Thompson

11 BIRTHPLACE OF FATHER (city or town): unknown

(State or country)

12 MAIDEN NAME OF MOTHER: Rebecca Wade

13 BIRTHPLACE OF MOTHER (city or town): unknown

(State or country)

14 Informant: Margon Gould

(Address): 214 N. Mount

Filed Jan 24 1927 C. HAMPSON JONES, M. D. Registrar

Per _____

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 24 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 16 1927 to Jan 24 1927, that I last saw h..... alive on Jan 20 1927, and that death occurred, on the date stated above, at 12 30 A m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) Uraemia Eclampsia

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Urine Test

Signed 24/27 J Norwood, M. D.

Jan 24, 1927 (Address) 939 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — Date of Burial: Jan 25 1927

20 UNDERTAKER: Katie R. Williams — ADDRESS 522 N. Schroeder St.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18244

## CERTIFICATE OF DEATH.

160 E 18244

1-PLACE OF DEATH

City of BALTIMORE. (No. 2402 Fredrick Ave St. W-6 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Calvert Eugene Withers

(a) RESIDENCE NO. 2402 Fredrick Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov. 13/26

7 AGE — Years 2 Months 9 Days. IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country)

PARENTS

10 NAME OF FATHER: Arthur W. Withers

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Balto.

12 MAIDEN NAME OF MOTHER: Susie Howard

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md

14 Informant: Susie Withers

(Address) 2402 Fredrick ave

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

Dec 1927

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22nd 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Malnutrition

Since Birth (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jos. B. Horton M. D.

(Coroner)

Jan 23rd, 1927 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery Date of Burial Jan 24 1927

20 UNDERTAKER: George L. Schwab ADDRESS 2101 Druid Ave

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18245

## CERTIFICATE OF DEATH.

129 E 18245

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 217 S. Ann ST. 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph W. Wathen

(a) RESIDENCE NO. 217 S. Ann ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rose Wathen

6 DATE OF BIRTH (month, day, and year): May 6, 1858

7 AGE: Years 68. Months 8 Days 21 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Locomotive Engineer Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Penna R R

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Harry Abrahams

(Address): 726 S Decker

Rec'd JAN 24 1927 C. HANSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 22 1927

17

I HEREBY CERTIFY, That I attended deceased from 1/1, 1927, to 1/22, 1927.

that I last saw h alive on 1/20 1927

and that death occurred, on the date stated above, at 4:30 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Chronic Interstitial Nephritis

(duration) Not Known yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Sig +

(Signed) Harry Strahan, M. D.

, 1927 (Address) 726 S Decker

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cem

DATE OF BURIAL: Jan 27 1927

UNDERTAKER: John Merrick

ADDRESS: 2108 Eden

Spec.—1-10-21—M&T—1500 Bks.

E 18246

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18246

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 407 N. Brice ST. 20-27 WARD) 100-801

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anton Kiffor

(a) RESIDENCE NO. 407 N. Brice ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? 21 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| M | W | Widower |

5a If married, widowed or divorced
HUSBAND of
~~(or) WIFE of~~ Franciska Kiffor

6 DATE OF BIRTH (month, day, and year) Mar. 21-1856

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 70 | 9 10 | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B. & O. R. R.

9 BIRTHPLACE (city or town) (State or country) Hungaria

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungaria

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungaria

14 Informant Geo Ledeg

(Address) 407 N. Brice St

15 FILED 1-24 1927, 19 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/21 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan 9, 1927, to Jan 21, 1927.

that I last saw h alive on Jan 20, 1927.

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 1 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? ✓

What test confirmed diagnosis? Clinical

(Signed) E Heller Hemming M. D.

1/22, 1927 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem; DATE OF BURIAL Jan: 24 1927

20 UNDERTAKER C. W. Dill ADDRESS 3109 Fredk: Ave:

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

**E 18247**

## CERTIFICATE OF DEATH.

159-00 E 18247

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 15-58 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby (Girl) Scher

(a) RESIDENCE NO. 2906 Norfolk Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1-22-27.

7 AGE — Years | Months | Days: 1 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto Md.

(State or country)

PARENTS

10 NAME OF FATHER Carlos H. Scher

11 BIRTHPLACE OF FATHER (city or town) Balto., Md.

(State or country)

12 MAIDEN NAME OF MOTHER Sophy Schultz

13 BIRTHPLACE OF MOTHER (city or town) Philadelphia Pa

(State or country)

14 Informant Hosp Records

(Address)

15 Filed 1-24 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-23-27. 19

17 I HEREBY CERTIFY, That I attended deceased from 1-23, 1927, to 1-23, 1927, that I last saw h[illegible] alive on 1-23, 1927, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Patent Foramen Ovale.

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Atelectasis

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Weinstraub, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Friendship — Date of Burial 1-24 1927

20 UNDERTAKER Jack Levin, ADDRESS 1139 Balto

Spec.—1-10-21—M&T—1500 Bks.

Champin

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18248

## CERTIFICATE OF DEATH.

129 E 18248

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 572½ N. Gay ST. 5-8 WARD)

2-FULL NAME Howard V. Champin

(a) RESIDENCE NO. 572½ N Gay ST., ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 13 1880

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 46 | 9. | 10 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Automobile Painter

(b) General nature of industry, business, or establishment in which employed (or employer) 050

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Butte City

PARENTS

10 NAME OF FATHER Ambrose Champin

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER E. Courtney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Miss May Champin (Address) 572½ N Gay St

15 JAN 24 1927 C. HAMPSON JONES, M.D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 24, 1926 to Jan 22, 1927.

that I last saw h alive on Jan 22 1927

and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Diffuse Nephritis

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Myocardial Insuffic

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) W. E. Hearn, M. D.

Jan 22, 1927 (Address) 1301 N Pat Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem DATE OF BURIAL Jan 24 1927

20 UNDERTAKER Jos M. Frank Dir ADDRESS Balto

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18249

101-001

## CERTIFICATE OF DEATH.

26-37

E 18249

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 345 S 12th ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leon Gantz

(a) RESIDENCE NO. 345 S 12th ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 2 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | Single |

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 15 1926

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min |
|---|---|---|---|---|
| | | 2 | 8 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore md

PARENTS

10 NAME OF FATHER Frank Gantz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto md

12 MAIDEN NAME OF MOTHER Anna Jakowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto md

14 Informant Frank Gantz

(Address) 345 S 12th St

15 Filed 1/23 1927 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan - 20, 1927, to Jan - 23, 1927, that I last saw him alive on Jan - 22, 1927 and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:

Acute Sobar Pneumonia Primary.

(duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no. Date of

Was there an autopsy? no.

What test confirmed diagnosis? clinical

(Signed) David Davidow M. D.

1/23 1927 (Address) 1222 N Gay St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Mt Lebanon | Jan 24 1927 |

20 UNDERTAKER John Maberg ADDRESS 1803 Bank St

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18250

## CERTIFICATE OF DEATH

90 E 18250

REGISTERED NO. 26-37

1-PLACE OF DEATH University Hospital

City of RALTIMORE: (No. ____ St. ____ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary F. Feehley

(a) RESIDENCE NO. 4613 Eastern Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Timothy Feehley

6 DATE OF BIRTH (month, day, and year): Feb 28, 1870

7 AGE: Years 56 Months 10 Days 24 (23) If LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Valentine Zoeller

11 BIRTHPLACE OF FATHER (City or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Streckfus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) [illegible]

14 Informant Ethel Feehley

(Address) 4613 Eastern Ave

15 JAN 24 1927 HAMPSON JONES, M. D. Registrar

Per [signature]

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 Jan. 21 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 20, 19 27 to Jan. 21, 19 27

that I last saw her alive on Jan 21 19 27

and that death occurred, on the date stated above, at 4:45 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia Cardio Vascular Disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Fibrosis

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank A. Bruchy M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — Date of Burial: Jan 25 1927

20 UNDERTAKER: George J Smith — ADDRESS: 432 Hollins St

Spec.—12-9-25—A Co.—200 Bks.

E 18251

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90

E 18251

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 400 N. Fulton Ave St. 20-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Axel Eriksen

(a) RESIDENCE NO. Home for the Aged of the M.E. St. Church Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. ✓ mos. ✓ ds. How long in U. S., if of foreign birth? 45 yrs. ✓ mos. ✓ ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widower |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maria Eriksen

6 DATE OF BIRTH (month, day, and year) June 30 1850

| 7 AGE | Years | Months | Days | IF LESS than 1 day ... hrs. or ... min. |
|---|---|---|---|---|
| | 76 | 6 | 22 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook aboard vessel

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer Unknown

9 BIRTHPLACE (city or town)

(State or country) Sweden

PARENTS

10 NAME OF FATHER Gustav Eriksen

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Sweden

12 MAIDEN NAME OF MOTHER Sophia Morner

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Sweden

14 Informant Etta Lindsay

(Address) 400 N. Fulton Ave

Filed JAN 24 1927 E. HAMPSON JONES, M. D. Registrar

By [illegible]

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 22 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Dec. 5, 1926, to Jany 22, 1927, that I last saw h[illegible] alive on Jany 21, 1927, and that death occurred, on the date stated above, at 5 p. m.

The CAUSE OF DEATH* was as follows:

Bronchitis Chronic

(duration) 3 yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) ✓ yrs. 4 mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No. Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis? Clinical methods

(Signed) George C. Shannon, M. D.

1/25, 1927 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet Date of Burial Jan 24 1927

20 UNDERTAKER George J. Smith ADDRESS 1532 Hollins

Spec.—1-12-23—M&T—500 Bks.

E 18252 HEALTH DEPARTMENT—CITY OF BALTIMORE 4002 10 E 18252

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST. 25-32 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine J. Goldhammer

(a) RESIDENCE NO. 634 Indiana Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 26, 1926

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 3 | 0 | 27 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Thomas J. Goldhammer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Bessie Talbot

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant (Address) Thomas J. Goldhammer 634 Indiana Ave

Filed 1-24, 1927 C. HAMPSON JONES, M. D. Registrar

Per RH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 22, 1927, to Jan 23, 1927, that I last saw her alive on Jan 23, 1927, and that death occurred, on the date stated above, at 6:00 a.m. m.

The CAUSE OF DEATH* was as follows:

Tonsillar & Pharyn. Diphtheria

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Myron G. Sulle, M. D.

1-27, 1927 (Address) Sydenham Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount DATE OF BURIAL Jan 26 1927

20 UNDERTAKER Wm. Leary & Son ADDRESS Eutaw & Lanvale

Spec.–7-17-26—A Co.—200 Bks.

Dr Todd 7 Somerset Road

HEALTH DEPARTMENT—CITY OF BALTIMORE

L. 18253

## CERTIFICATE OF DEATH

129 E 18253

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 3324 Alto Ave St. 15-61 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Hoffman

(a) RESIDENCE NO. 3324 Alto Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred / yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Grace A. Hoffman

6 DATE OF BIRTH (month, day, and year): July 26 1855

7 AGE: Years 71 Months 5 Days 26 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer):

(r) Name of employer

9 BIRTHPLACE (city or town): Balt

(State or country): Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Eleanor A. Linn

13 BIRTHPLACE OF MOTHER (city or town): Balt

(State or country): Md

14 Informant: Grace A. Hoffman

(Address): 3324 Alto Ave

15 Filed JAN 24 1927 Registered

C. HAMPSON JONES, M. D.

Per RH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 22 19 27

17 I HEREBY CERTIFY, That I attended deceased from Jan 15 1927 to Jan 22 1927

that I last saw her alive on Jan 22 1927

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Right Kidney)

(duration) 10 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary): Oedema of Lungs

(duration) yrs. mos 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P.E.

(Signed) Simon C. Todd M. D.

1/24 1927 (Address) 735 N. Eutaw Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet

Date of Burial: 1/27 19 27

20 UNDERTAKER: M. Cook

ADDRESS: Fairfield

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18254

## CERTIFICATE OF DEATH

113

E 18254

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1804 N Milton Ave (Street) 8-16 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth D Thompson

(a) RESIDENCE NO. 1804 N Milton Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S. if of foreign birth yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 5 26

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | | 2 | 18 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER Willard E Thompson

11 BIRTHPLACE OF FATHER (City or town) Baltimore Md

(State or country)

12 MAIDEN NAME OF MOTHER Mildred Marker

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Brooklyn N Y

14 Informant Willard E Thompson

(Address) 1804 N Milton Ave

15 Filed JAN 24 1927 16 C. HAMPSON JONES, M. D. Registrar.

1631 E Madison

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 5 1926 to Jan 23 1927

that I last saw her alive on Jan 10 1927

and that death occurred, on the date stated above, at 12 P M.

The CAUSE OF DEATH* was as follows:

Acute Ileo Colitis

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Where was disease contracted

If not at place of death?

Did an operation precede death? NW Date of

Was there an autopsy? NW

What test confirmed diagnosis?

(Signed) E. Gill Hall M. D.

Jan 23 1927 (Address) 1631 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

Date of Burial Jan 25 1927

20 UNDERTAKER Williams & Son

ADDRESS 502 E North Ave

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 18255 — 1-PLACE OF DEATH

26-37 90

E 13255 — REGISTERED NO.

City of BALTIMORE: (No. _____ St., 26-37 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME annie hendricks

(a) RESIDENCE NO. Chambersburg, Pa. Ward

(Usual place of abode) 15 (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) dec 1, 1858 (?)

7 AGE: Years 39 | Months 1 | Days 4 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housework

(b) General nature of industry, business, or establishment in which employed (or employer) D.1 10

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Winfield S Hendricks

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Pa.

12 MAIDEN NAME OF MOTHER Emma Lichty

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Pa.

14 Informant City Hospital Records

(Address)

15 Filed JAN 24 1927, 19 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22 19 27

17 I HEREBY CERTIFY, That I attended deceased from May 18, 1924 to Jan. 22, 1927 that I last saw h[illegible] alive on Jan. 22, 1927 and that death occurred, on the date stated above, at 4.15 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis - chronic - acute arteriosclerosis. Hypertension Hemiplegia - residual

(duration) 1 yrs. 8 mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? (?)

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? General - Sect.

(Signed) C. Holmes Boyd, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — Date of Burial Jan 26 1927

20 UNDERTAKER W. M. Cook — ADDRESS 307 E. Lombard

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18256 58-001 E 18256

## CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 5-8 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Kyne

(a) RESIDENCE NO. 700 E Lexington St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? 1873

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 54 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer) Oil

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER John Kyne

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Foland

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant City Hospitals Records

(Address)

15 Filed....., 19 C. HAMPTON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 20, 1927, to Jan 22, 1927, that I last saw him alive on Jan 22, 1927 and that death occurred, on the date stated above, at 12 A. m.

The CAUSE OF DEATH* was as follows:

Pernicious Anaemia

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General & Subs

(Signed) C. Holmes Boyd, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's Homelike Date of Burial Jany 1927

20 UNDERTAKER Wilbain Bal ADDRESS 52 E Balto

Spec.—1-12-23—M&T—500 Blks.

Norman T. Burns

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 18257

CERTIFICATE OF DEATH Norman T. Burns

E 18257

1-PLACE OF DEATH West Baltimore General Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Raynor and Dukeland ST., 9-H WARD)

2-FULL NAME Norman T. Burns

(a) RESIDENCE NO. 3631 Old York Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. 4 mos. 27 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Pauline M. Burns

6b DATE OF BIRTH (month, day, and year) Aug. 25 1898

7 AGE: Years 28 | Months 4 | Days 27 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cable Splicer for C&P

(b) General nature of industry, business, or establishment in which employed (or employer) C&P Telephone Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Joseph F. Burns

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Julia Kramer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs. Pauline M. Burns

(Address) 3631 Old York Road

Filed JAN 24 1927 H. HAMPSON JONES, M. D.

Per Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-22, 1927

17 I HEREBY CERTIFY, That I attended deceased from 1/19, 1927, to 1/22, 1927

that I last saw him alive on 1/22, 1927

and that death occurred, on the date stated above, at 11 40 A.m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Benjamin Miller, M. D.

1/24, 1927 (Address) W. Balto Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: Jan 25 1927

20 UNDERTAKER: Henry Hoeck Son — ADDRESS: 1301 E Eager St

Spec.-7-17-26—A Co.—200 Bks.

E 18258

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

90 E 18258

1-PLACE OF DEATH

City of BALTIMORE: (No. 1018 Forrest St. 10-15 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hannah C. Morrell

(a) RESIDENCE NO. 1018 Forrest St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. — mos. — ds. How long in U. S. if of foreign birth? 74 yrs. — mos. — ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Not Known

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min.. |
|---|---|---|---|---|
| | 75 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Patrick Morrell

11 BIRTHPLACE OF FATHER (City or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Anna Connelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Catherine Fitzgerald

(Address) 1019 Valley St

15 Filed JAN 24 1927, 19 C. HAMPSON JONES, M. D., Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 23rd 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 23, 1927, to Jan 23, 1927, that I last saw h[illegible] alive on Jan 23 1927, and that death occurred, on the date stated above, at 9.55 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Bernard Lowe, M. D.

1/24 1927 (Address) 914 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral County — Date of Burial Jan 26 1927

20 UNDERTAKER Henry Hoerle Son — ADDRESS 1301 E Eager St

Spec.—7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

8259

## CERTIFICATE OF DEATH

12E 18259

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No.) 1605 E. Lanvale (St.) 8-17 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theresa M. Blumenauer

(a) RESIDENCE NO. 1605 E Lanvale St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. 8 mos. 3 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles J. Blumenauer

6 DATE OF BIRTH (month, day, and year): May 20 1858

7 AGE — Years: 68 Months: 8 Days: 3 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Balto (State or country) Md

PARENTS

10 NAME OF FATHER: Karl Stubert

11 BIRTHPLACE OF FATHER (City or town): (State or country) Germany

12 MAIDEN NAME OF MOTHER: Catherine Elbaser 1824

13 BIRTHPLACE OF MOTHER (city or town): (State or country) Germany

14 Informant: Mr. Charles J. Blumenauer

(Address) 1605 E Lanvale St

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 Jan. 23rd

17 I HEREBY CERTIFY, That I attended deceased from Jan 20, 1927, to Jan 23rd, 1927, that I last saw h— alive on Jan 23rd, 1927, and that death occurred, on the date stated above, at 10.20 P. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia R
Right Side

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage
Chronic Nephritis

(duration) Unknown ds.

18 Where was disease contracted —

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Jeffries Brecht M. D.

(Address) 2846 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Holy Redeemer Cemetery | Jan. 27 1927 |
| **20 UNDERTAKER** | **ADDRESS** |
| Kenny Stork & Son | 1301 E Eager St |

Spec.—1-12-23—M&T—500 Blks.

199285 E 18260

# HEALTH DEPARTMENT—CITY OF BALTIMORE

1-001 E 18260

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 64 ST. WARD)

2-FULL NAME Lucille Russell

(a) RESIDENCE No. 207 N. Caroline St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6½ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Col | Baby |

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 1922

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| 4 | 4 | 9 | 0 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Jack Russell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Dorse

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records JOHNS HOPKINS HOSPITAL (Address)

Filed JAN 24 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1927, to Jan 22, 1927, that I last saw her alive on Jan. 22, 1927, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 17 ds.

CONTRIBUTORY (Secondary) Typhoid fever ?

(duration) yrs. mos. 17 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) A B Block, M. D.

, 19 (Address) J H H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Laurel Cemetery | 1/26/27 |
| 20 UNDERTAKER | ADDRESS |
| Mrs. P. G. Elliott | 1725 Ashland Ave |

Spec.—1-12-23—M&T—500 Bks.

E 18261

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

98 E 18261

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital 21-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman Charles Nagala

(a) RESIDENCE No. 1233 Sargent ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 5 mos. 7 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of.

6 DATE OF BIRTH (month, day, and year) Aug 15 1926

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | | 5 | 7 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — DAD

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Charles Nagala

11 BIRTHPLACE OF FATHER (city or town) Hamilton (State or country) Ohio

12 MAIDEN NAME OF MOTHER Myrtle R Hodaway

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Mrs Charles Nagala

(Address) 1233 Sargent St

15 Filed 4 1926 Per H. BAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22 1926

17 I HEREBY CERTIFY, That I attended deceased from Jan 17, 1926, to Jan 22, 1926, that I last saw h(m) alive on Jan 22, 1926, and that death occurred, on the date stated above, at 7-40 P m.

The CAUSE OF DEATH* was as follows:

Spanemic bronchopneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. mos. 17 ds.

18 Where was disease contracted if not at place of death? Maternum

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical evidence, autopsy

(Signed) Lewis Alda Taunton, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem — DATE OF BURIAL Jan. 25 1926

20 UNDERTAKER John J Fields — ADDRESS 1201 N Fountain St

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18262

## CERTIFICATE OF DEATH.

160

E 18262

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hospital ST. 1-26 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Merryman

(a) RESIDENCE NO. Fulham Corgate md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 8. 24

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 2 | 3 | 14 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Milton Merryman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Elizabeth Jones

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) md

14 Informant Hospital Records (Address)

15 Filed 2-4, 1927, 19 C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-22 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 20, 1927, to Jan 22, 1927, that I last saw h in alive on Jan 22, 1927, and that death occurred, on the date stated above, at 10.4 m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Starvation

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) C. Hampson Jones M. D.

, 19 (Address) Md Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel DATE OF BURIAL Jan 25 1927

20 UNDERTAKER John F Denny ADDRESS 715 Lyd St

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18263

## CERTIFICATE OF DEATH.

× 88 E 18263

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 27 S. Eleventh ST., 176-37 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucile Florence Townsend

(a) RESIDENCE NO. 27 S. Eleventh ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred - yrs. 8 mos. - ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 22d 1924

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 2 | 4 | 1 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER William Townsend

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Lena Hayer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Lena Townsend

(Address) 27 S. Eleventh St.

15 Filed JAN 24 1927 19 By — Registrar

C. HAMPSON JONES, M. D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 23 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 12, 1927, to Jan 23, 1927, that I last saw her alive on Jan 23, 1927 and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis
defective Heart from
birth (duration) 2 yrs. 4 mos 1 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) Horace [illegible] M. D.

1/24, 1927 (Address) 8N. Highlandtown

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Meherrin, Va.

DATE OF BURIAL Jan. 27 1927

20 UNDERTAKER Zirkler & Zirkler

ADDRESS 1739 E. Eager St.

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18264

## CERTIFICATE OF DEATH.

89 E 18264

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1015 Hollins St ST. 18-29 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Kellert

(a) RESIDENCE NO. 1015 Hollins St ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harry Kellert

6 DATE OF BIRTH (month, day, and year): autumn

7 AGE: Years 44 | Months — | Days — | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Israel Levin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Gitka Blest

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: a Hostess

(Address)

15 Filed JAN 24 1927, 19

C. HAMPSON JONES, M. D.

Per ... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 23 19 27

17 I HEREBY CERTIFY, That I attended deceased from Jan 23, 1927, to ..., 19 ...,

that I last saw her alive on 2:30 PM Jan 23, 1927

and that death occurred, on the date stated above, at 4:50 PM

The CAUSE OF DEATH* was as follows:

Angina Pectoris

4 hours (duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Hypertension (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Balto.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Jacob Cohen, M. D.

1/24/, 1927 (Address) 223 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Wilson Lodge — DATE OF BURIAL: 1/25 19 27

20 UNDERTAKER: Jack Lewis — ADDRESS: 1439 E Baltimore St

Spec.—1-10-21—M&T—1500 Blks.

E 18265 HEALTH DEPARTMENT—CITY OF BALTIMORE E 18265

CERTIFICATE OF DEATH

74-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1903 Barclay ST. 17-19 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry D Webb

(a) RESIDENCE NO. 1903 Barclay ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. 5 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Sophia K Webb

6 DATE OF BIRTH (month, day, and year) July 27th 1851

| 7 AGE | Years | Months | Days 26 | If LESS than 1 day, ....hrs. or min. |
|---|---|---|---|---|
| | 75 | 5 | 24 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gold & Silver Burnisher

(b) General nature of industry, business, or establishment in which employed (or employer) Schofield Herr & Co

(c) Name of employer do

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Leander Webb

11 BIRTHPLACE OF FATHER (city or town) (State or country) Philadelphia Pa

12 MAIDEN NAME OF MOTHER Rosemarie Wirth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Sophia K Webb

(Address) 1903 Barclay st

15 1927 C. HAMPSON JONES, M. D., Registrar

Per

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 25, 1927

17 I HEREBY CERTIFY, That I attended deceased from January 10, 1927. to January 25, 1927.

that I last saw h(im) alive on January 25, 1927.

and that death occurred, on the date stated above, at 4.05 P. m.

The CAUSE OF DEATH* was as follows:

Pleurisy.

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dwight C Franklin, M. D.

1, 27, 1927 (Address) 424 E. North ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery DATE OF BURIAL Jan 25th 1927

20 UNDERTAKER George Schilling & Sons ADDRESS 1126 E Monument

Spec.—12-9-25—A Co.—200 Bks.

E 18266 HEALTH DEPARTMENT—CITY OF BALTIMORE E 18266

CERTIFICATE OF DEATH. 31

1-PLACE OF DEATH REGISTERED NO. 14-20

City of BALTIMORE: (No. Baltimore City Hospitals (J.H.H. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Hunter

(a) RESIDENCE NO. 1418 McCulloh st. St. Ward

(Usual place of abode) Length of residence in city or town where death occurred Unknown yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maggie Hunter

6 DATE OF BIRTH (month, day, and year) 1893

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 33 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town)

(State or country) Florida

PARENTS

10 NAME OF FATHER Page Hunter

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Florida

12 MAIDEN NAME OF MOTHER Mollie Edwards

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Hospital Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per 0975

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 Janeury 21, 1927

17 I HEREBY CERTIFY, That I attended deceased from January 17 1927, to January 21, 1927, that I last saw h... alive on January 21, 1927, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Tuberculous Laryngitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Spontaneous Pneumothorax

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H E Gattens M. D.

1-21-27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial JAN 24 19 1927

20 UNDERTAKER ADDRESS

Commissioner Health.

Spec.—1-10-21—M&T—1500 Bks.

E 18267

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18267

## CERTIFICATE OF DEATH.

4-2161-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 225 N. Pine ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Newman

(a) RESIDENCE NO. 225 N. Pine ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Baby

6 DATE OF BIRTH (month, day, and year): 1-22-27

| 7 AGE | Years | Months | Days | If LESS than 1 day, ½ hrs. or min. |
|---|---|---|---|---|
| | | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baby

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Bossie Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Elizabeth Newman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pennsylvania

14 Informant

(Address)

15 1927 C. HAMPSON JONES, M. D.

Register

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1-22-1927

17 I HEREBY CERTIFY, That I attended deceased from 1-22-1927 to 1-22-1927

that I last saw him alive on 1-22-1927

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Prematurity (24 wks)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Ena F. Dodge M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: 19 JAN 24 1927

20 UNDERTAKER

ADDRESS

Commissioner Health.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18268

E 18268

## CERTIFICATE OF DEATH

92

REGISTERED NO. 16-1

1-PLACE OF DEATH

City of BALTIMORE: (No. 714 S. Clinton St. St. 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Tholinda Schenk.

(a) RESIDENCE NO. 714 S. Clinton St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow. |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Schenk.

6 DATE OF BIRTH (month, day, and year) Jan. 21 - 1848

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..hrs. or ..min.. |
|---|---|---|---|---|
| | 79 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 027

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany.

PARENTS

10 NAME OF FATHER John Bauer

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Gerlach

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Selestine Pattersonich

(Address) 716 S. Clinton St.

15 Filed 4 1927 C. HAMPSON JONES, M. D. Registrar

Per ADA

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 22 - 1927

17 I HEREBY CERTIFY, That I attended deceased from January 14, 1927, to January 22, 1927, that I last saw h.. alive on January 22, 1927, and that death occurred, on the date stated above, at 2.20 P. m.

The CAUSE OF DEATH* was as follows:

Coronary Embolism 3 days.

Arterial Sclerosis

(duration) 2 yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Caleb R. Athey, M. D.

(Address) 120 S. Patterson Park Ave. Jan 24, 1927

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem. Date of Burial Jan 26 - 1927

20 UNDERTAKER Libby & Feiler ADDRESS 1035 N. Wolfe St.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18269

## CERTIFICATE OF DEATH.

E 18269

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hosp. St., 7th Ward)

REGISTERED NO. 188-052

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Jackson

(a) RESIDENCE NO. 6010 Eastern Road St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Jackson

6 DATE OF BIRTH (month, day, and year) Dec 19th 1879

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 47 | 1 | 2 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Elias Pitzpatrick

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Canada

12 MAIDEN NAME OF MOTHER Cath. McCann

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Charles Jackson

(Address)

15 Date Jan 24 1927 C. HAMPSON JONES, M. D. Registrar

Per

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 21, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) automobile accident

(duration) yrs. mos. ds.

(Signed) J. T. Kenney M. D. (Coroner)

Jan 25, 27 (Address) 2502 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial Jan 25 1927

Cathedral Cemetery

20 UNDERTAKER Lilly & Feiler ADDRESS 4038 Wolfe St

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

**E 18270** 74-001 **E 18270**

## CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 503 N. Castle St., 7-4 Ward)

2-FULL NAME Elizabeth Gross

(a) RESIDENCE NO. 503 N. Castle St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? Life mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 ~~Single~~, Married, Widowed, or ~~Divorced~~ (write the word): Married

6a If married, widowed, or divorced (or) WIFE of: William A. Gross

6 DATE OF BIRTH (month, day, and year): June 24 - 1855

7 AGE: Years 71 | Months 6 | Days 28 | IF LESS than 1 day ...hrs. or ...min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md.

PARENTS

10 NAME OF FATHER: Conard Reder

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Not Known

14 Informant: Clara Waldman

(Address) 503 N Bradford St

15 4 1927 C. HAMPSON JONES, M. D. Registrar

Per [illegible]

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 22 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 15, 1926, to Jan 22, 1927, that I last saw h... alive on Jan 21, 1927, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Hysterectomia

Cerebral Apoplexy

(duration) ...yrs. 7 mos. ...ds.

CONTRIBUTORY (Secondary): Myocardial Insufficiency Pulmonary Edema.

(duration) ...yrs. ...mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm G Keyser M. D.

, 19 (Address) 156 N. Mellon Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem. Date of Burial Jan 25 1927

20 UNDERTAKER: Wm G Fuller & Son ADDRESS 2334 Jeffer...

Spec.—1-10-21—M&T,—1500 Bks.

E 18271

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18271

## CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2521 N. Fairmount Ave ST. 20 WARD) 69

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Elizabeth Kraemer

(a) RESIDENCE NO. 2521 N. Fairmount Ave ST., ..... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. 5 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Female | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Kraemer

6 DATE OF BIRTH (month, day, and year) Aug 17 1852

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or ..... min. |
|---|---|---|---|---|
| | 74 | 5 | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Jefferson Barker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Kraemer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Miss Kathie Kraemer (Relative)

(Address) 2521 N. Fairmount Ave.

15 JAN 4 1927 C. HAMPSON JONES, M. D. Registrar

Per .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 23rd 1927

17

I HEREBY CERTIFY, That I attended deceased from Dec 4th, 1926, to Jan. 23rd 1927

that I last saw h er alive on Jan. 22nd 1927

and that death occurred, on the date stated above, at 6:20 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) Chronic Pneumonitis (duration) 1 yrs. — mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Hypostatic Congestion

(Signed) Paul Brown, M. D.

Jan 24, 1927 (Address) 1837 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Jan 26 1927

20 UNDERTAKER: C. Carson Kennard — ADDRESS: 226 W. Lafayette Ave

Spec.—1-12-23—M&T—500 Blks.

E 18272 HEALTH DEPARTMENT—CITY OF BALTIMORE E 18272

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bon Secours Convent 2077 31 REGISTERED NO.....

CITY OF BALTIMORE: (No. 2000 W. Baltimore ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister Albus, Ellen O'Brien, Bon Se Cour Convent.

(a) RESIDENCE NO. 2000 W. Baltimore ST., ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 21, 1906

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs or ... min. |
|---|---|---|---|---|
| | 20 | 11 | 30 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Roman Catholic Sister

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Philadelphia, Pa.,

PARENTS

10 NAME OF FATHER James O'Brien

11 BIRTHPLACE OF FATHER (city or town) (State or country) Philadelphia, Pa.,

12 MAIDEN NAME OF MOTHER Anna Larkin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Philadelphia, Pa.,

14 Informant Rev. Mother Juliana (Address) 2000 W. Baltimore

15 1927 C. HAMPSON JONES, M. D. Registrar

Per .....

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 21 1927

17 I HEREBY CERTIFY, That I attended deceased from August 2nd. 1926, to January 21. 1927, that I last saw h. alive on January 21, 1927 and that death occurred, on the date stated above, at 11 Pm.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dan V. Cronahan M. D.

1/24. 1927 (Address) 24 N. Fulton Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Cathedral Cem | 1/25 1927 |

20 UNDERTAKER George A Farley ADDRESS Fulton & Fayette

Spec.–7-17-26—A Co.—200 Bks.

E 18273

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

90 E 18273

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 415 N. Eurley. St., 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret O. Neal.

(a) RESIDENCE NO. 415 N. Eurley. St. 6 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 10 mos. 22 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow. |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late John T. O. Neal.

6 DATE OF BIRTH (month, day, and year) Feb. 28th 1860.

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min.. |
|---|---|---|---|---|
| | 66 | 10 | 24 22 | |

8 OCCUPATION OF DEACEASED

(a) Trade, profession or particular kind of work Retired.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md.

(State or country)

PARENTS

10 NAME OF FATHER Michael Buehl.

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Elizabeth Bickel

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany.

14 Informant Charles A. O. Neal (Son)

(Address) 415 N. Eurley St.

15 Filed C. HAMPSON JONES, M. D. Registrar

1927 Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 Jan 22nd

17 I HEREBY CERTIFY, That I attended deceased from Nov 17, 1924, to Jan 22, 1927, that I last saw h alive on Jan 22, 1927, and that death occurred, on the date stated above, at 4:35 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Uremia

(duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY Chronic Valvular Heart Disease

(Secondary)

(duration) 2 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Chas. Heller, M. D.

(Address) 1937 Bonaparte

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

Date of Burial Jan. 25th 1927

20 UNDERTAKER Lilly + Zeiler

ADDRESS 4038 Wolfe St

Spec.—1-12-23—M&T—500 Bks.

E 18274

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18274

## CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1501 Eutaw Place St. 14-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna L. Whitehurst

(a) RESIDENCE NO. 1501 Eutaw Place ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widowed |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 13, 1847

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs or ... min. |
|---|---|---|---|---|
| 79 | 80 | 1 | 10 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Maryland

PARENTS

10 NAME OF FATHER William McIlvain

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Charlotte Benton

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Milton U. Whitehurst
(Address) 1501 Eutaw Place

15 Filed JAN 4 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 23 1927

17

I HEREBY CERTIFY, That I attended deceased from Dec 20, 1926, to Jan 23, 1927.

that I last saw him alive on Jan 23, 1927

and that death occurred, on the date stated above, at 10.45p m.

The CAUSE OF DEATH* was as follows:

Anemia myocarditis

Arteriosclerosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial suffering

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) W. H. Smith, M. D.

Jan. 13 1927 (Address) 3524 Greenmount Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Loudon Park Cem | Jan 26 1927 |
| 20 UNDERTAKER | ADDRESS |
| Joseph B Cook | 1003 N Calvert St |

Spec.—12-9-25—A Co.—200 Bks.

# E 18275

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 ✓ E 18275

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 3644 Elm Ave. St., 13-52 Ward)

2-FULL NAME Nettie V. Taylor

(a) RESIDENCE NO. 3644 Elm Ave. St. 13 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. — mos. — ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Browne L. Taylor

6 DATE OF BIRTH (month, day, and year) Sept. 29-1894

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 32 | 3 | 23 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) ?

(State or country) Virginia

PARENTS

10 NAME OF FATHER George W. Slather

11 BIRTHPLACE OF FATHER (city or town) ?

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Arndorff

13 BIRTHPLACE OF MOTHER (city or town) ?

(State or country) Virginia

14 Informant Browne L. Taylor

(Address) 3644 Elm Ave.

15 Jan 24 1927 C. HAMPSON JONES, M. D.

Per _____ Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 January 22-27

17 I HEREBY CERTIFY, That I attended deceased from Jan 17, 1927, to Jan 22, 1927, that I last saw her alive on Jan 22, 1927, and that death occurred, on the date stated above, at 10 40 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) _____

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? Don't Know

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's (Hampden) Date of Burial Jan 25 1927

20 UNDERTAKER Horace F. Burgee ADDRESS 363 Falls Road

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18276

## CERTIFICATE OF DEATH

E 18276

REGISTERED NO. 101-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 2435 W. North Ave. St.) (Ward) 15-58

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eleonora Virginia Paulus

(a) RESIDENCE NO. Reisterstown Rd & Keyworth Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 82 yrs. 5 mos. 26 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | White | Widow. |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George A. Paulus.

6 DATE OF BIRTH (month, day, and year) July 27, 1844

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min.. |
|---|---|---|---|---|
| | 82 | 5 | 26 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Co.

(State or country) Md.

PARENTS

10 NAME OF FATHER August Spelshouse

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Elise Dorothy Hoff

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs Margaret Spelshouse

(Address) 2435 W. North Ave.

4 1927 C. HAMPSON JONES, M. D.

Per ASA Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27th 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 18, 1927, to Jan 27, 1927, that I last saw her alive on Jan 21, 1927, and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) James A Ashburst, M. D.

(Address) 3017 Park Heights ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cem. Date of Burial Jan. 29 1927

20 UNDERTAKER W. J. Fickus Sons ADDRESS North Ave

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18277.

## CERTIFICATE OF DEATH

31 E 18277

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 4521 Harford Rd St. 27-44 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfonso Cortolillo

(a) RESIDENCE NO. 4521 Harford Rd St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Cortolillo

6 DATE OF BIRTH (month, day, and year): Nov. 30 1893

7 AGE: Years 33 Months 1 Days 24 (23)

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Barber

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Italy

PARENTS

10 NAME OF FATHER: Anthony Cortolillo

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Italy.

12 MAIDEN NAME OF MOTHER: Lucy Sakero

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Italy.

14 Informant: Mrs. Mary Cortolillo

(Address): 4521 Harford Rd

15 Filed 1927 C. HAMPSON JONES, M. D., Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 23 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 22, 1927, to Jan 23, 1927,

that I last saw h[illegible] alive on Jan 22, 1927,

and that death occurred, on the date stated above, at 6.30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary & Laryngeal Tuberculosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Do not know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. L. Leahy M. D.

1-24, 1927 (Address) 4218 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem. Date of Burial: Jan 25 1927

20 UNDERTAKER: Wm J Tickner & Sons ADDRESS: North Pa

Spec.—1-10-21—M&T—1500 Bks.

E 18278 HEALTH DEPARTMENT—CITY OF BALTIMORE E 18273

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1707 N Chapel ST., 8-17 90 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth M. Kuttern

(a) RESIDENCE NO. 1707 N Chapel ST., ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John E. Kuttern.

6 DATE OF BIRTH (month, day, and year): Sept 17-1872

7 AGE — Years: 84 — Months: 4 — Days: 5 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: John E. Seyler.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Margaret Seyler (Address) 1707 N Chapel

15 1-4 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 22 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 26, 1926, to Jan 22, 1927, that I last saw h N alive on Jan 20, 1927, and that death occurred, on the date stated above, at 6 15 a m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) Jacob Frahm, M. D.

1/27, 1927 (Address) 1823 N. Washington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Schwartz Cem

DATE OF BURIAL: Jan 25 1927

20 UNDERTAKER: John Merrick

ADDRESS: 2403 Eutaw

Spec.—1-10-21—M&T—1500 Bks.

E 18279

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18279

## CERTIFICATE OF DEATH.

X 86-80

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Md General Hosp ST. 11-24 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Bertha Kiatt

(a) RESIDENCE No. 2400 Brick Dive ST., Woodlawn WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F. | W | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: C. A. Kiatt

6 DATE OF BIRTH (month, day, and year) Feb 28, 1885

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| 41 | 41 | 10 | 24 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: H. W. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Syracuse New York

PARENTS

10 NAME OF FATHER Howard A Dean

11 BIRTHPLACE OF FATHER (city or town) (State or country) N York.

12 MAIDEN NAME OF MOTHER Ada Westcott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Canada

14 Informant Hospital Records

(Address)

15 1927 C. HAMPSON JONES, M. D. Registrar

Per AKH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-22 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan 17, 1927, to Jan 22, 1927, that I last saw h[illegible] alive on Jan 22, 1927, and that death occurred, on the date stated above, at 3.41 P. m.

The CAUSE OF DEATH* was as follows:

Meningitis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Pulmonary edema & Uremia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? Yes Date of 1-17-27

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Jas A Hampson Jones M. D.

, 19 (Address) Md Gen Hospl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem. DATE OF BURIAL: Jan 25 1927

20 UNDERTAKER: Jos Jacobs & Son ADDRESS: 217 S. Bro[illegible]

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18280

## CERTIFICATE OF DEATH.

8-45 90

REGISTERED NO. E 18280

1-PLACE OF DEATH

City of BALTIMORE: (No. 1617 E. 25th St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elmer Allen Ropka

(a) RESIDENCE NO. 1617 E 25th St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine P. Ropka

6 DATE OF BIRTH (month, day, and year) Sept 19, 1889

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 37 | 4 | 4 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) B & O R. R.

(c), Name of employer

9 BIRTHPLACE (city or town) Baltimore Co Md

(State or country)

PARENTS

10 NAME OF FATHER Henry W. Ropka

11 BIRTHPLACE OF FATHER (city or town) Balto. Md.

(State or country)

12 MAIDEN NAME OF MOTHER Ida Swimmer

13 BIRTHPLACE OF MOTHER (city or town) Balto Md

(State or country)

14 Informant Katherine P. Ropka

(Address) 1617 E. 25th St.

Filed JAN 25 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23 1927

17 I HEREBY CERTIFY, That I attended deceased from 5/15/25 19..., to 1.23.27, 19...,

that I last saw h... alive on 1.23.27, 19...,

and that death occurred, on the date stated above, at 12.15 P.M.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) ...yrs. ...mos. 5 ds.

CONTRIBUTORY (Secondary) Tricuspid Insufficiency

(duration) 5 yrs. ...mos. ...ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Philip B. Towles, M. D.

1.24.1927 (Address) 1482 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Date of Burial Jan 25 1927

20 UNDERTAKER ADDRESS

Wm. Mrs. John H. Penfold & Son 801 W. Fayette

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18281

## CERTIFICATE OF DEATH.

E 18281

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 111 N Bentalou ST. 70-69 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Becraft

(a) RESIDENCE NO. 111 N Bentalou ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Jan 19, 1904

7 AGE: Years 23 Months Days 3 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Louis E. Becraft

11 BIRTHPLACE OF FATHER (city or town) (State or country): Mt. Airy Md.

12 MAIDEN NAME OF MOTHER: Nellie Ford

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Fairmount Md.

14 Informant: Nellie Becraft

(Address) 111 N Bentalou st

15 Filed 1-25 1927 19

C. HAMPSON JONES, M.D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-22-1927

17

I HEREBY CERTIFY, That I attended deceased from Jan. 4 1925 to Jan 22 1927.

that I last saw her alive on Jan 20 1927.

and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) W. Sample, M. D.

1/24 1927 (Address) 1013 Poplar Grove st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

DATE OF BURIAL: 1-25 1927

UNDERTAKER: Robert Brooks & Son

ADDRESS: Calhoun Hollins st

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18282

## CERTIFICATE OF DEATH

REGISTERED NO. E 18282

1-PLACE OF DEATH St. Joseph's Hospital

CITY OF BALTIMORE: (No.) Caroline & Oliver (ST.) 645 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Hall.

(a) RESIDENCE NO. 2335 Harford Rd. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widower |

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Ebert

6 DATE OF BIRTH (month, day, and year) Aug. 19, 1864

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 62 | 5 | 4 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bailiff

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Tax Department

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Jesse K. Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Ann Kellan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Viola Rettaliata (Address) 2335 Harford Avenue

15 Filed JAN 25 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 23 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 12, 1927, to Jan. 23, 1927 that I last saw him alive on Jan. 23, 1927 and that death occurred, on the date stated above, at 7.35 P. m.

The CAUSE OF DEATH* was as follows:

Acute Ruptured appendicitis.

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Fecal Fistula.

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes. Date of Jan. 15 1927

Was there an autopsy? no

What test confirmed diagnosis? operation.

(Signed) A. L. McAnally, M. D.

19 (Address) St. Joseph's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL 1/27 19 27

20 UNDERTAKER Henry U. Mears & Son

ADDRESS 605 N. Calvert

Spec.—1-10-21—M&T—1500 Bks.

18283

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18283

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Scott

REGISTERED NO. 164

CITY OF BALTIMORE: (No. 1141 Lorst St 21-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Kulen

(a) RESIDENCE No. 1141 Lorst St. 21 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word) |
|---|---|---|
| Male | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Christina Kulen

6 DATE OF BIRTH (month, day, and year) Sept 21 1844

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 82 | 4 | 3 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Kulen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Christina

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John Kulen

(Address) 1141 Lorst St

15 FILED 1 25 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1927, to Jan 25, 1927, that I last saw h alive on Jan 24, 1927, and that death occurred, on the date stated above, at 6.30 P.M.

The CAUSE OF DEATH* was as follows:

Senile Decay

(duration) yrs. — mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

1/26, 1927 (Address) 517 Scott St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Jan 26 1927

20 UNDERTAKER John J Fields — ADDRESS 1200 W Fayette

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18284

## CERTIFICATE OF DEATH.

89 E 18284

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 114 E. 33rd ST. 12-49 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rev Theodore Clinton Foote

(a) RESIDENCE NO. 114 E 33rd St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Leila Maud Wilson

6 DATE OF BIRTH (month, day, and year) July 26 1857

| 7 AGE Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|
| 69 | 5 | 26 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Minister

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Dobbs Ferry
(State or country) New York

PARENTS

10 NAME OF FATHER Theodore C Foote

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Mass ?

12 MAIDEN NAME OF MOTHER Mary E Hunt

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) unknown

14 Informant Mrs Leila Wilson Foote
(Address) 114 E. 33rd St

15 Filed 1-25 1927 C. HAMPSON JONES, M. D.
Registrar
By R.H.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) January 22 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1926 to January 22 1927.

that I last saw him alive on January 22, 1927.

and that death occurred, on the date stated above, at 9-40 P. m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis,
Angina Pectoris
Cardiac Insufficiency + Myocarditis
(duration) yrs. 3 mos 2 ds.

CONTRIBUTORY (Secondary) General Arterio-sclerosis
(duration) 20 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs.

(Signed) W. Gibson Porter, M. D.

1/24 1927 (Address) 422 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Druid Ridge Cemetery | Jan 25 1927 |
| 20 UNDERTAKER | ADDRESS |
| Joseph Gibbons Sons | Mulford & Orchard |

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18285

## CERTIFICATE OF DEATH.

90 E 13285

15-67

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3 Prospect Circle ST., WARD)

2-FULL NAME Louise Klevenstueber Schwarz

(a) RESIDENCE NO. 3 Prospect Circle ST., WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 3 mos. 24 ds. How long in U. S., if of foreign birth? 60 yrs. 3 mos. 24 ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gustav H. Schwarz

6 DATE OF BIRTH (month, day, and year) Oct-1-1866

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 60 | 3 | 24 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Frederick Klevenstueber

11 BIRTHPLACE OF FATHER (city or town) ? ? (State or country) Germany

12 MAIDEN NAME OF MOTHER Louise Heinsens

13 BIRTHPLACE OF MOTHER (city or town) ? ? (State or country) Germany

14 Informant Mrs. R. W. Britt (Daughter)

(Address) 3 Prospect Circle

15 Filed 1927, 19 C. HAMPSON JONES M. D. Registrar

For

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 4, 1926, to Jan 24, 1927, that I last saw her alive on Jan 24, 1927, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Organic heart disease - mitral incompetency

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) None known

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. exam.

(Signed) Chas Keller, M. D.

Jan. 1927 (Address) 722 W. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Jan-26-27 19

20 UNDERTAKER: STEWART & MOWEN COMPANY

ADDRESS

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18286

## CERTIFICATE OF DEATH.

E 18286

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Granada Apts St. 1359 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hannah Rothschild

(a) RESIDENCE No. Granada Apts St. W. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Seligman Rothschild

6 DATE OF BIRTH (month, day, and year) June 29, 1839

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 87 | 6 | 24 26 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Judah Bush

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Gertie Straus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Friedman

(Address) Granada Apts

15 Filed JAN 25 1927

HAMPSON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/23/1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 19, 1927, to Jan. 23rd, 1927, that I last saw h... alive on Jan. 23rd, 1927, and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) Harry Rosenthal, M. D.

, 19 (Address) 3704 Liberty Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem.

DATE OF BURIAL 1/25/1927

20 UNDERTAKER Harry Londheim

ADDRESS 1820 W. Mt. Royal Ave.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18287

## CERTIFICATE OF DEATH.

74-001

E 13287

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2424 Callow Ave St. 13-59 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME David L. Jacob

(a) RESIDENCE NO. 2424 Callow Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Judith Jacob

6 DATE OF BIRTH (month, day, and year): About 1856

7 AGE: Years: About 70 Months: Days: IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Merchant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Russia

PARENTS

10 NAME OF FATHER: Leib Jacob

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Russia

14 Informant: Aaron Jacob

(Address) 2424 Callow Ave

15 Filed JAN 25 1927 19 H. HAMPSON JONES M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/24/1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:*

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) [illegible] M. D.

(Coroner)

1/24, 1927 (Address) 3672 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pikesville Hebrew Cem. Date of Burial: 1/25/1927

20 UNDERTAKER: Chas. Sondheim ADDRESS 111-20 W. Pratt St. Boyd Line

Cor.—12-9-25—A Co.—200 Bks.

E 18288

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

146

E 18288

1-PLACE OF DEATH

REGISTERED NO._____

City of BALTIMORE: (No. 2023 E. Fayette St., 6-9 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Agnes Leono

(a) RESIDENCE NO. 2023 E. Fayette St. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Femal | White | Married |

5a If married, widowed, or divorced (or) WIFE of Joseph Leono

6 DATE OF BIRTH (month, day, and year) May 30/83

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 43 | 7 | 23 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) City

(State or country) Jan 27

PARENTS

10 NAME OF FATHER John Schneider

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Louisa Adams

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Joseph Leono

(Address) 2065 E. Fayette St

JAN 25 1927 HAMPSON JONES, M. D.

Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 23, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Emergency Septicemia

(duration) .....yrs. .....mos. 2/ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) J. T. Hampson M. D.

(Coroner)

Jan 27, 1927 (Address) 280 Hendenson Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs., .....mos., .....ds. In the State .....yrs., .....mos., .....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — Date of Burial 1/26 1927

20 UNDERTAKER Philip Henning — ADDRESS 2016 Aliceanna St

Spec.—1-1927—Part—500 Blks.

19867

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18289

## CERTIFICATE OF DEATH.

E 18289

REGISTERED NO. 113

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 7-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irelvin Hale

(a) RESIDENCE NO. 709 Lafayette Ave ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| male | white | |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9-2-26.

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | | 4 | 21 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Arthur Hale

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary Massenbetter

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed JAN 25 1927 C. HAMPSON JONES, M. D.
Per ..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 23 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 27, 1926, to Jan 23, 1927
that I last saw h[illegible] alive on Jan 23, 1927
and that death occurred, on the date stated above, at 6 15 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Otitis Media (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X Ray

(Signed) Thomas W. Cornwall, M. D.

, 19 Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel — DATE OF BURIAL 1/26 1927

20 UNDERTAKER Philip Harvey — ADDRESS 2016 Orleans St

Cor.—12-9-25—A Co.—200 Pks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18290

## CERTIFICATE OF DEATH.

52 E 18290

REGISTERED NO.____

1-PLACE OF DEATH

City of BALTIMORE: (No. #213 N. Chapel St. 6-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John M. Kunkel

(a) RESIDENCE NO. #213 N. Chapel St. St.____ Ward____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 5th. 1860

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 66 | 4 | 19 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Produce

(b) General nature of industry, business, or establishment in which employed (or employer) Business

(c) Name of employer Himself

9 BIRTHPLACE (city or town)____

(State or country) Balto.

PARENTS

10 NAME OF FATHER Michael Kunkel

11 BIRTHPLACE OF FATHER (city or town)____

(State or country) Germany

12 MAIDEN NAME OF MOTHER Bregetta ----

13 BIRTHPLACE OF MOTHER (city or town)____

(State or country) Germany

14 Informant Tina Schuler (sister)

(Address) #213 N. Chapel St.

JAN 25 1927 C. HAMPSON JONES, M. D.

Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/24/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Endocarditis

____ (duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) History Arthritis —

____ (duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. S. H. Owens, M. D.
(Coroner)

1/24/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the state.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?____

Former or usual residence____

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Holy Redeemer | 1/26/27 |

20 UNDERTAKER Philip Herwig ADDRESS 2016 Orleans St

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

54-002

E 18291

REGISTERED NO. E 18291

1-PLACE OF DEATH

City of BALTIMORE: (No. 1509 Riggs Av. St., 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Mackel

(a) RESIDENCE NO. 1509 Riggs Av St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | Col | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 21-27

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | | | 1 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Jas. H. Mackel

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Beatrice Coyne

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Beatrice Mackel

(Address) 1509 Riggs Ave.

Filed JAN 25 1927, 19..... C. HAMPSON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 22, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Premature Birth

(duration) .....yrs. .....mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) J. J. Young M. D. (Coroner)

Jan 22, 1927 (Address) 2502 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dr. Jno Conn Date of Burial 1/26 1927

20 UNDERTAKER Sam'l Chase Wm ADDRESS 1100 Madison

Spec—12-23-21—E.B.R.S.—400 Eks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18292 129 E 18292

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.

City of BALTIMORE: (No.) 1121 Eutaw St. 17-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia J. Griffin

(a) Residence No. 1121 Eutaw St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Fe | 4-COLOR OR RACE, Col | 5-Single, Married, Widowed, Divorced, (write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of James Griffin

6-DATE OF BIRTH (month, day and year) 1865

7-AGE. 62 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) O'

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Susan Palmer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Sadie Bartlett

(Address) 975-N Fayette

15- Filed JAN 25 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan. 22 1927

17- I HEREBY CERTIFY, That I attended deceased from Jan. 7 1927 to Jan 22 1927

that I last saw h alive on Jan 22 1927

and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

Duration yrs. mos. ds.

CONTRIBUTORY (Secondary)

Duration yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) P. Garland Lafferty M. D.

Jan 24 1927 (Address) 1534 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Bonnet | DATE OF BURIAL. Jan 25 1927

20-UNDERTAKER Jas H. Crouse Son | ADDRESS 1400 Mosher

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18293

## CERTIFICATE OF DEATH.

E 18293

1-PLACE OF DEATH. Hamilton

CITY OF BALTIMORE: (No.) Glenmore Ave near Belair Road (Ward) 43

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Elizabeth Jones

(a) RESIDENCE NO. Glenmore near Belair Road WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Jones

6 DATE OF BIRTH (month, day, and year): 1853 June 12

7 AGE: 74 Years | 7 Months | 13 Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work:

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer:

9 BIRTHPLACE (city or town): (State or country) Md.

PARENTS

10 NAME OF FATHER: Charles Jordan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Nova Scotia

12 MAIDEN NAME OF MOTHER: Harriett Booze

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Daughter
(Address)

15 Filed JAN 25 1927 HAMPSON JONES, M. D. Registrar
Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/25 1927

17 I HEREBY CERTIFY, That I attended deceased from 1/1/27, 1927, to 1/25, 1927, that I last saw h[illegible] alive on 1/25, 1927 and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Hyla W. Holley, M. D.

, 1927 (Address) 5012 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Cemetery Harford Co. Md. DATE OF BURIAL: Jan 28th 1927

20 UNDERTAKER: Bomberger & Sons ADDRESS: Benson Md.

Spec. 6-9-19—H. P. Co.—1000 Blks.

E 18294

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 E 18294

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 816 Tyson ST. 11-24 WARD)

2-FULL NAME Hiram Thomas Jr

(a) RESIDENCE. No. 816 Tyson ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs mos ds. How long in U. S., if of foreign birth? yrs mos ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | Col | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 10-1904

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 22 | 4 | 12 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work General Light work

(b) General nature of Industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. City
(State or country)

PARENTS

10 NAME OF FATHER Hiram Thomas Sr

11 BIRTHPLACE OF FATHER (city or town) Balto City
(State or country)

12 MAIDEN NAME OF MOTHER Elenor Carter

13 BIRTHPLACE OF MOTHER (city or town) Balto City
(State or country)

14 Informant Chas J Keller,
(Address) 722 W Lanvale

15 Filed JAN 25 1927, 19 . E. HAMPSON JONES, M.D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 9. 1927. to Jan. 22. 1927.
that I last saw h.. alive on Jan 21. 1927.
and that death occurred, on the date stated above, at 1.45 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) — yrs. 10 mos. — ds.

CONTRIBUTORY (Secondary) None known

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical exam.

(Signed) Chas J Keller, M. D.

1/26. 1927 (Address) 722 W. Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem DATE OF BURIAL Jan 25 27

20 UNDERTAKER Samuel A Hensley ADDRESS 678 N Eutaw

Spec.–7-17-26—A Co.—200 Bks.

Dr Keech 2502 Calvert Rd

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18295

## CERTIFICATE OF DEATH

164 E 18295

1-PLACE OF DEATH

City of BALTIMORE: (No. 227 N. Calhoun St., 14-26 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E Wiley

(a) RESIDENCE NO. 227 N. Calhoun St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1/2 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm Wiley

6 DATE OF BIRTH (month, day, and year): Dec. 21- 1841

7 AGE: Years 85 Months 1 Days 2 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: (X) Woman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Hector Perkins

11 BIRTHPLACE OF FATHER (City or town) (State or country): Hartford Conn

12 MAIDEN NAME OF MOTHER: Ann. Reed

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Rev Chas E. Perkins

(Address) 1420 Carswell St

JAN 25 1927 HAMPSON JONES, M. D.

Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): January 23rd 1927

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1926, to Jan. 23, 1927.

that I last saw h.m. alive on Jan. 22 1927

and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Infirmities of Age

(duration) yrs. 9 mos. – ds.

CONTRIBUTORY (Secondary): Cachexia Dyspepsia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) H. Hobart Keech M. D.

Jan 24 1927 (Address) 2502 Calvert Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: D. Baltimore Cemetery

Date of Burial: 1/25 1927

20 UNDERTAKER: Uncertain Co

ADDRESS: 502 E Mt St

Spec.—7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18296

## CERTIFICATE OF DEATH

× 145-001

E 18296

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. 4-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Jenkins

(a) RESIDENCE NO. Sparks Md St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 10 1908

7 AGE: Years 19 Months Days 13 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Maid

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Co

PARENTS

10 NAME OF FATHER: Green Hackney

11 BIRTHPLACE OF FATHER (City or town) (State or country): Balto Co

12 MAIDEN NAME OF MOTHER: Pearl Jenkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Co

14 Informant (Address): Mary Lawson Sparks Md

15 Filed N 25 1927 Per R.R.

CHARLES JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: Jan 23 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 17, 1927, to Jan 23, 1927, that I last saw h[illegible] alive on Jan 23, 1927, and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Paralytic Ileus & Obstruction

2—3 days (duration)

CONTRIBUTORY (Secondary) (Caesarean Section) 8½ months Pregnancy (duration)

18 Where was disease contracted if not at place of death? Upstairs (Caesarean Section)

Did an operation precede death? yes Date of Jan 18-27

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) R.S. Anderson M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Balto Co Date of Burial Jan 26 19 27

21 UNDERTAKER: W.E. Brooks ADDRESS Sparks Md

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18297

101-801 E 18297

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 107 W. Henrietta St. 23-31 Ward)

2-FULL NAME Josephine Perticone

(a) RESIDENCE NO. 107 W. Henrietta St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Francesco Perticone

6 DATE OF BIRTH (month, day, and year): Sept. 30-1879

7 AGE: 47 Years | Months: 3 | Days: 24 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: H. W.

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town): Italy

(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town): Italy

(State or country)

12 MAIDEN NAME OF MOTHER Ciccia Caponetti

13 BIRTHPLACE OF MOTHER (city or town): Italy

(State or country)

14 Informant: Francesco Perticone

(Address) 107 W. Henrietta St.

Filed APR 25 1927 HARRY JONES

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/24 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan 12 1927, to Jan 24, 1927,

that I last saw h[illegible] alive on Jan 23, 1927,

and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ...yrs. ...mos. 12 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 1 yrs. ...mos. ...ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Rudolph L. Kuhlcke, M. D.

1927 (Address) 1038 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Cathedral Cem. Date of Burial: 1/27 1927

20 UNDERTAKER: George J. Ruth ADDRESS: 1235 Harford Ave.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 18298 — 31 E 18298

REGISTERED NO. 21-29

1-PLACE OF DEATH

City of BALTIMORE: (No. 725 W. Cross St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles H Klein

(a) RESIDENCE NO. 725 W. Cross St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9[illegible] yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, ~~Married, Widowed, or Divorced~~, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 9 - 1879

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| 47 | 47 | 2. | 13 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clothing Cutter
(b) General nature of industry, business, or establishment in which employed (or employer) 08
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Henry G Klein
11 BIRTHPLACE OF FATHER (City or town) Baltimore Md
(State or country)
12 MAIDEN NAME OF MOTHER Sophia Lang
13 BIRTHPLACE OF MOTHER (City or town) Baltimore Md
(State or country)

14 Informant J. R. McCaleb
(Address) 2152 Mosher st. Balto

Filed JAN 25 1927 19 H. C. HAMPSON JONES, M. D. Registrar
Per RJK

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1927, to Jan 22, 1927, that I last saw him alive on Jan 21, 1927 and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Auscultation Leo K.

(Signed) J M Dellert, M. D.

Jan 24. 1927 (Address) 621 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery Date of Burial July 25 19 27

20 UNDERTAKER Chas J Snyder ADDRESS 1412 N Broadway

Very Important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 E 18299

E 18299

## CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH West Balto General Hospital

CITY OF BALTIMORE: (No. Fayette and Greene St. 14-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Dale

(a) RESIDENCE NO. 54 W. Mulberry ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX female | 4 COLOR OR RACE colored | 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Jan 16, 1925

| 7 AGE Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|
| 2 | 7 | 7 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mary Land

PARENTS

10 NAME OF FATHER Gingy Beverly

11 BIRTHPLACE OF FATHER (city or town) (State or country) V. A.

12 MAIDEN NAME OF MOTHER Ida Mary Dail

13 BIRTHPLACE OF MOTHER (city or town) (State or country) V. A.

14 Informant Ida Mary Dail

(Address) 54 W. Mulberry St

15 Filed JAN 25 1927 C. HAMPTON JONES, M. D. Registrar

Per RK

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/23 19 27

17 I HEREBY CERTIFY, That I attended deceased from 12/9 , 19 26 to 1/23 , 1927.

that I last saw her alive on 1/23 , 1927

and that death occurred, on the date stated above, at 12 5-7 m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) acute cardiac dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings

(Signed) Benjamin Mills, M. D.

, 19 (Address) W. 3 P. St.

*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary Cty

DATE OF BURIAL Jan 25 1927

20 UNDERTAKER Leonard Waller

ADDRESS Myrtle 306-308 Ave

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18300

## CERTIFICATE OF DEATH.

10 E 18300

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Josephs Hospital

CITY OF BALTIMORE: (No. Caroline & Oliver ST. 19-27 WARD)

2-FULL NAME Mrs. Elizabeth. Schroeder

(a) RESIDENCE NO. 20 N. Stricker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | white | Separated. |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 22, 1881

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 45 | 11 | 27 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Musician. do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England.

PARENTS

10 NAME OF FATHER John J. Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) England.

12 MAIDEN NAME OF MOTHER Margaret Handley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England.

14 Informant Mrs John J. Bopper

(Address) 502 Vidukisk Road

15 Filed 2 5 1927. 19 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 17, 1927, to Jan 23, 1927, that I last saw her alive on Jan. 23, 1927, and that death occurred, on the date stated above, at 10:05 p m.

The CAUSE OF DEATH* was as follows:

Brain Abscess

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Respiratory Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) Frank R. DeGaul, M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cem. W. A. Co. Md. DATE OF BURIAL 1/26 1927

20 UNDERTAKER: Chas. R. Mace & Son 1181 W. Baltimore ADDRESS

Spec.-7-17-26—A Co.—200 Bks.

E 18301

# HEALTH DEPARTMENT—CITY OF BALTIMORE

10-0 E 18301

## CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 401 N. Fulton Ave. St. 19-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie S. Kiser,

(a) RESIDENCE NO. 401 N. Fulton Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 8 mos. 21 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 3, 1925

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min.. |
|---|---|---|---|---|
| | 1 | 8 | 21 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland,

PARENTS

10 NAME OF FATHER Chester L. Kiser,

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Carroll Co. Md.

12 MAIDEN NAME OF MOTHER Mary Edna Drake,

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Md.

14 Informant Chester L. Kiser,
(Address) 401 N. Fulton Ave,

15 Filed 19 Registrar.

By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JAN 24 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Jan 16, 19 27, to Jan 24, 19 27,

that I last saw h alive on Jan 24, 19 27,

and that death occurred, on the date stated above, at 8 30 P. m.

The CAUSE OF DEATH* was as follows:

(Broncho Pneumonia)

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Acute Endocarditis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. D.

1/25, 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Date of Burial JAN 25 1927 19

20 UNDERTAKER Geo W. Little ADDRESS 2708

Spec.—1-10-21—M&T—1500 Bks.

E 18302

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18302

## CERTIFICATE OF DEATH.

101 201

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1506 Morrison Ct ST. 25-77 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susie B. McGarrity

(a) RESIDENCE NO. 1506 Morrison Ct ST. Curtis Bay WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ed McGarrity

6 DATE OF BIRTH (month, day, and year): Sept 17. 1881

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 45 | 4 | 5 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Jos. Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Ed. McGarrity

(Address): 1506 Morrison Court Curtis Bay

15 Filed JAN 25 1927

17 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 22 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 21, 1927, to Jan 22, 1927, that I last saw h[illegible] alive on Jan 22, 19, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas Brooks M. D.

, 1927 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem.

DATE OF BURIAL: Jan 25 1927

20 UNDERTAKER: Margaret A Flynn

ADDRESS: 1422 Light St

Spec.—12-9-25—A Co.—200 Bks.

Buchwald.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

90

E 18303

## CERTIFICATE OF DEATH.

REGISTERED No. E 18303

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 908 Appleton St. 16-22 Ward)

2-FULL NAME Margaretha Buchwald

(a) RESIDENCE NO. 908 Appleton St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 Color or Race: Wht

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec 11 91

7 AGE: Years 35 | Months 1 | Days 17 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 069
(c) Name of employer

9 BIRTHPLACE (city or town): Balto.
(State or country): Md.

PARENTS

10 NAME OF FATHER: F G Buchwald

11 BIRTHPLACE OF FATHER (city or town):
(State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Kochler

13 BIRTHPLACE OF MOTHER (city or town):
(State or country): Germany

14 Informant: L C Buchwald
(Address): 631 N Bentalou

15 Filed JAN 25 1927, 19 HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 23 19 27

17 I HEREBY CERTIFY, That I attended deceased from Nov 20 19 26, to Jan 23, 19 27,
that I last saw h..... alive on Jan 23, 19 27,
and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary): Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted
If not at place of death? No
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) H J Norwood, M. D.
Jan, 19 (Address) 439 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Bern — Date of Burial: Jan 26 1927

20 UNDERTAKER: W M Routson — ADDRESS: 2235 N Mo Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

Kwat

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18304

## CERTIFICATE OF DEATH.

112

E 18304

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1519 Lamont St. 4-18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.— Walter E. Kwat.

(a) RESIDENCE. NO. 1519 Lamont St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) May 16-1926

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | | 8. | 7 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER - Martin Kwat

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Pauline Gstrich

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant - Mrs John Gastrock

(Address) 1519 Lamont Ave

Filed ___ 19 ___ C. HAMPSON JONES, M. D. Registrar

JAN 25 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan 20 1927, to Jan 23 1927,

that I last saw h alive on Jan 23 1927,

and that death occurred, on the date stated above, at 6.20 m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Asthenia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C. Hampson Jones M. D.

1/24 1927 (Address) 1519 Lamont

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Cedar Hill Cemetery | 1/26 1927 |

20 UNDERTAKER George J Ruth ADDRESS 1735 Harford

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18305 E 18305

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 76 Annapolis Av ST., WARD) 25-32

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katie Fleet

(a) RESIDENCE NO. 76 Annapolis Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs or ... min. |
|---|---|---|---|---|
| | 40 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Arthur Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Lizzie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Edna Fleet

(Address) 72 Annapolis Ave.

15 Filed 5 1927 C. HAMPSON JONES, M. D. Registrar

By RHL

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-22- 1927

17

I HEREBY CERTIFY, That I attended deceased from 1-20 1927 to 1-22- 1927

that I last saw h alive on 1-22- 1927

and that death occurred, on the date stated above, at 10P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Grippe

(duration) yrs. mos. V ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clifford Davis M. D.

, 19 (Address) 229 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery — DATE OF BURIAL: Jan 26 1927

20 UNDERTAKER: Mrs. G. H. Hooper — ADDRESS: 406 Conway St.

Spec.—1-12-23—M&T—500 Blks.

E 18306 (1927)

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18306

## CERTIFICATE OF DEATH.

101-08

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Slacum

(a) RESIDENCE No. 1910 E. Madison ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE: Years 53; Months —; Days —; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Enameler

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 086

9 BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Wm Slacum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary J. McCready

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

Filed 5-1927 C. HAMPSON JONES, M. D.

Per Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 21, 1927, to Jan 22, 1927, that I last saw h alive on Jan 22, 1927, and that death occurred, on the date stated above, at 9.10 P m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Milton Aaron, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Wm. gate Md. DATE OF BURIAL: 1/26/27

20 UNDERTAKER: Wm R. A. Elliott ADDRESS: 725 Ashland

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18307 E 18307

## CERTIFICATE OF DEATH.

REGISTERED NO 15-2129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 624 Gold (ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nancy Jones

(a) RESIDENCE NO. 624 Gold ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | C | Widowed |

5a If married, widowed, or divorced (or) WIFE of

6 DATE OF BIRTH (month, day, and year) exactly unknown apparently 1870

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| 51 | 56 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Annapolis Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25 1927

17 I HEREBY CERTIFY, That I attended deceased from Last Part Dec. 1926 to Jan 25 1927.

that I last saw h alive on Jan 23 1927.

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis (duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Myocarditis and Generalized Anasarca (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R J Young M. D.

1/25 1927 (Address) 729 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

14 Informant Robert Valentine (son in law) (Address) 624 Gold St

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Auburn — DATE OF BURIAL 1/26/27

20 UNDERTAKER Mrs. Ida Snowden — ADDRESS 1725 Ashland Ave

15 Filed 5 1927 C. HAMPSON JONES, M. D., Registrar

Rec'd

Spec.—12-9-25—A Co.—200 Bks.

E 18308

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18308

## CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 76-37 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lee Flowers

(a) RESIDENCE NO. Grant Springs, Appamattox Co Virginia Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | Negro | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1906 estimated

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 21 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) Grant Springs

(State or country) Appamattox Co Virginia

PARENTS

10 NAME OF FATHER Henry Flowers

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Annie —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant

(Address) Records

15 Date 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 22 1927

17

I HEREBY CERTIFY, That I attended deceased from January 21, 1927, to January 22, 1927, that I last saw him alive on January 22, 1927, and that death occurred, on the date stated above, at 4:35 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? gen'l & Laboratory

(Signed) O. Hooper Judd, M. D.

Jan. 25 1927 (Address) 1165

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary Date of Burial 1/26/27

20 UNDERTAKER Geo. R. G. Elliott ADDRESS 1725 Eastland Ave

E 18309

# HEALTH DEPARTMENT--CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 18309

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 71- Parkwood av ST.) No. 71 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 12.)

2-FULL NAME Laura Virginia Eakle

(Residence in Baltimore: No. 2121- Virginia av Hagerstown Md yrs. mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, or DIVORCED (Write the word): Single

6-DATE OF BIRTH: Aug (Month) 24 (Day) 1852 (Year)

7-AGE: 74 yrs 5 mos 1 ds. If LESS than 1 day, ..... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): Ind.

9-BIRTHPLACE (State or country): Dilmington Washington Co Md

PARENTS

10-NAME OF FATHER: Caleb Eakle

11-BIRTHPLACE OF FATHER (State or country): Maryland

12-MAIDEN NAME OF MOTHER: Sarah C Bear

13-BIRTHPLACE OF MOTHER (State or country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Norman Jreaps

(Address) 24 Parkwood av

15- Filed 5 1927 Per 191 C. HAMPSON JONES, M. D. Acid REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: January (Month) 25 (Day) 1927 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan-13 1927, to Jan-25 1927, that I saw h[illegible] alive on Jan-24 1927, and that death occurred, on the date stated above, at 10 40 A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia (Lobular)

(Duration) yrs mos 13 ds

Contributory (SECONDARY) Cardiac Failure

(Duration) yrs mos ds

(Signed) C Hampson Jones M. D.

Jan-25 1927 [Address] 1802 Rosely av Md

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State yrs mos ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Hagerstown Md

DATE OF BURIAL: Jany 27 1927

20-UNDERTAKER: A. K Coffman

ADDRESS: Hagerstown Md

E 18310 HEALTH DEPARTMENT—CITY OF BALTIMORE E 18310

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Maryland General Hospital 17-26 84 Registered No. C.....

City of BALTIMORE: (No. Madsion St. & Linden Ave. St., ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Sullivan

(Residence in Baltimore: No. 641 W Franklin St. St.; yrs..... mos.... 2Hours

## PERSONAL AND STATISTICAL PARTICULARS.

| 3-SEX. | 4-COLOR OR RACE. | 5-Single, Married, Widowed, or Divorced, (Write the word.) |
|---|---|---|
| Female | White | Married |

6-DATE OF BIRTH. Aug. (Month) 1884 (Day) 1 (Year)

| 7-AGE. | If LESS than 1 day. |
|---|---|
| 42 yrs. 6 mos. ds. | hrs. or min.? |

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country). Mass.

PARENTS.

10-NAME OF FATHER. Murphy

11-BIRTHPLACE OF FATHER, (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Ellen Bunker

13-BIRTHPLACE OF MOTHER, (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

Gerald J. Sullivan
(Informant)

607 W 137th St. New York.
(Address)

15- Dec 5 1927

C. HAMPSON JONES, M. D.

192 Per ..... Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 23- (Day) 192 7 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pect.

(Duration) ..... yrs. ..... mos. 1 hrs.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) G. E. Pattee M. D.

Jan 23 192 7 (Coroner)

(Address) 143 W 13 ray

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. New York N.Y. DATE OF BURIAL. Jan 4 1927

20-UNDERTAKER. Harry H. Witzke ADDRESS 1534 W. Lombard St.

Spec.–7-17-26—A Co.—200 Bks.

E 18311

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 18311

129

REGISTERED NO. _____

1-PLACE OF DEATH

City of BALTIMORE: (No. 1922 Gough St. 7-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Majchrzak

(a) RESIDENCE NO. 1922 Gough St St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S. if of foreign birth? 40 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary Majchrzak

6 DATE OF BIRTH (month, day, and year) April 5 – 1874

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..hrs. or ..min.. |
|---|---|---|---|---|
| | 52 | 9 | 18 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) Carpenter 015

(c) Name of employer _____

9 BIRTHPLACE (city or town) _____
(State or country) Poland

PARENTS

10 NAME OF FATHER Joseph Majchrzak

11 BIRTHPLACE OF FATHER (City or town) _____
(State or country) Poland

12 MAIDEN NAME OF MOTHER Agnes Knapzak

13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country) Poland

14 Informant Mary Majchrzak
(Address) 1922 Gough St

15 JAN 1927 C. HAMPSON JONES, M. D.
P. _____ Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19
Jan 23 1927

17 I HEREBY CERTIFY, That I attended deceased from _____, 19 26, to 1/23, 19 27, that I last saw h alive on 1/22, 19 27, and that death occurred, on the date stated above, at 12 45 P m.

The CAUSE OF DEATH* was as follows:

Emphysema
Cerebral Hemorrhage
Chronic Interstitial Nephritis
_____ (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY _____
(Secondary)
_____ (duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted _____
If not at place of death? _____
Did an operation precede death? No Date of _____
Was there an autopsy? No
What test confirmed diagnosis? Physical Signs
(Signed) Samuel Theuer M. D.
, 19 27, (Address) 3520 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| St Stanislaus | Jan 26 1927 |
| 20 UNDERTAKER | ADDRESS |
| John M Weber | 1803 Fonta |

Spec.—1-12-23—M&T—500 Bks.

18312

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18312

## CERTIFICATE OF DEATH.

124

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Josephs. Hosp. (St.) (Ward) 43

2-FULL NAME Helen Gryadky

(a) RESIDENCE NO. 7112 Fleet. ST., WARD Hall Ty #34

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W

5 Single, (Married), Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Michael Grudzki

6 DATE OF BIRTH (month, day, and year): Apr 4- 1897

7 AGE: Years 29 | Months 9 | Days 17 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): At Home.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Michael Hepner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Emily Bochetsky

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Wladyslawa. Rydzewska

(Address) Bonita- Essex

FILED 1927 C. HAMPSON JONES, M. D. Registrar

By AKB

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 21 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1926. to January 21, 1927.

that I last saw her alive on January 21, 1927.

and that death occurred, on the date stated above, at 10 45 P. m.

The CAUSE OF DEATH* was as follows:

Cholecystitis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Post-operative pneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Dec. 23, 1926

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Frank R. DePaula, M. D.

1/27, 1927 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary

DATE OF BURIAL: 1/26 1927

20 UNDERTAKER: W. Fairbanks

ADDRESS: 1618 Eastern

Spec.-7-17-26—A Co.—200,Bks.

E 18313

# HEALTH DEPARTMENT—CITY OF BALTIMORE

179 E-18313

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. University Hospital St. 15-60 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Jackson

(a) RESIDENCE NO. 2717 Baker Street St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 8 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | white | (Single) Child |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 9th 1922

| 7 AGE | Years | Months | Days | IF LESS than 1 day ____hrs. or ____min.. |
|---|---|---|---|---|
| | 4 | 8 | 14 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General natore of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Creston E Jackson

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Baltimore

12 MAIDEN NAME OF MOTHER Ruth E. Carson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Washington De

14 Informant Ruth E Jackson

(Address) 2717 Baker St

15 Filed JAN 25 1927 C. HAMPSON JONES, M. D. Registrar

Per AKA

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 23 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Jan. 5 1927, to Jan. 23 1927,

that I last saw h[e] alive on Jan 22 1927,

and that death occurred, on the data stated above, at 7.45 A m.

The CAUSE OF DEATH* was as follows:

Second degree burns neck. Right side. Head and right groin. (Coma)

(duration) yrs. mos 12 da.

CONTRIBUTORY (Secondary) Bronchio-pneumonia

(doration) yrs. mos 5 da.

18 Where was disease contracted Ot Admission

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam. & Clinical

(Signed) Jacob Pleiss M. D.

. 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| London Park Cemetery | Jan 25 1927 |
| 20 UNDERTAKER | ADDRESS |
| Robert Brookeson | Calhoun Hollins |

Spec.—1-10-21—M&T—1500 Bks.

**E 18314** HEALTH DEPARTMENT—CITY OF BALTIMORE 90 **E 18314**

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 902 - Baltimore West ST., 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Smith.

(a) RESIDENCE NO. 102 - Baltimore ST., 25 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 4 mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | W | Widow |

5a If married, widowed, or divorced (or) ~~HUSBAND~~ WIFE of James Smith.

6 DATE OF BIRTH (month, day, and year) April 11 1841

| 7 AGE | Years | Months | Days | If LESS than 1 day.....hrs. or min. |
|---|---|---|---|---|
| | 85 | 9 | 17 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER John Daniels

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ellen Challis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant John W. Madary (Address) 902 Balto. St.

15 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 15 , 1925 . to Jan 23 , 1927

that I last saw her alive on Jan. 22 , 1927

and that death occurred, on the date stated above, at 6:40 P. m.

The CAUSE OF DEATH* was as follows: Acute Regurgitation

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

(Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Loudon Park Cemetery DATE OF BURIAL Jan 26 1927

20 UNDERTAKER George L. Schwartz ADDRESS 2101 Buck Ave.

Spec.—1-12-23—M&T—500 Bks.

E 18315

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18315

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO. 101-081

CITY OF BALTIMORE: (No.) ~~1~~ St. 21-31 Ward) 2

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Admiral M Lange

(a) RESIDENCE NO. 617 W. West St., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W. | M. |

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Orlea Lange

6 DATE OF BIRTH (month, day, and year) June 31-1876

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs or ....min. |
|---|---|---|---|---|
| | 50 | 11 | 23 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. County (State or country)

PARENTS

10 NAME OF FATHER Jacob Lange

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Mary Gerney

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JAN 25 1927 C. HAMPSON JONES, M. D., Registrar

Plan

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 21, 1927, to Jan 23, 1927, that I last saw h alive on Jan 23, 1927, and that death occurred, on the date stated above, at 8 05 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray

(Signed) Milton Shelley, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Mt Olivet Cemetery | Jan. 27 1927 |
| 20 UNDERTAKER George L. Schmidt | ADDRESS 2101 Eutaw Ave. |

Spec.—7-17-26—A Co.—200 Bks.

E 18316

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18316

## CERTIFICATE OF DEATH

REGISTERED NO. 49

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St. 700-28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Wright

(a) RESIDENCE NO. 1939 Lemmon St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| male | white | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jane Wright

6 DATE OF BIRTH (month, day, and year) Oct. 12 - 1869

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| 57 | | 3 | 12 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher

(b) General nature of industry, business, or establishment in which employed (or employer) 013

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Wright

11 BIRTHPLACE OF FATHER (City or town) Eng

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Mrs Mary Wright

(Address) 1939 Lemmon St

Filed JAN 25 1927

19 C. HAMPSON JONES M. D. Registrar

By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-24 1927

17 I HEREBY CERTIFY, That I attended deceased from 1-14, 1927, to 1-24, 1927,

that I last saw h~~e~~ alive on 1-24, 1927,

and that death occurred, on the date stated above, at 3 30 P m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

Cholecystitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma Head of pancreas

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Yes Date of 1-22-27

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Sherwood Hunter, M. D.

1/24. 1927 (Address) St. Agnes' Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery Date of Burial Jan. 28 1927

20 UNDERTAKER George Schmidt ADDRESS 1111 Hillsdale Ave

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18317.

## CERTIFICATE OF DEATH.

199 E 18317

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. West Balto Hospital, 9-46 Ward)

2-FULL NAME Catherine Siegenheim

(a) RESIDENCE NO. 1127 Homestead St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John H Siegenheim

6 DATE OF BIRTH (month, day, and year): Sept 20 1899

7 AGE: Years 27 Months 4 Days 7 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Md

PARENTS

10 NAME OF FATHER: John Eckert

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Austria

12 MAIDEN NAME OF MOTHER: Ellen Fowler

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md

14 Informant: John H Siegenheim

(Address): 1127 Homestead St

Jan 25 1927

C. HAMPSON JONES, M. D.

Registrar

Per

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 24 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

abortion, (self induced)

(duration) .....yrs. .....mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) J. J. Hennessy Mr D.

(Coroner)

(Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ..... mos., ..... ds. In the State ..... yrs., ..... mos., ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cem Date of Burial Jan 27 1927

20 UNDERTAKER: John Leerist

ADDRESS 285 Freemont St

Spec.—1-10-21—M&T—1500 Blks.

E 18318 HEALTH DEPARTMENT—CITY OF BALTIMORE E 18318

227 W Blvd

CERTIFICATE OF DEATH.

REGISTERED NO. 1928

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1840 N. Henry ST. (or WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles H. Garlach

(a) RESIDENCE NO. 1840 N. Henry ST. 25th WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 28th 1926

7 AGE Years Months 3 Days 26 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Carrol Garlach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Anna Doll

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Balto Md

14 Informant Carrol Garlach (Address) 1840 N. Henry St

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-24-1927

17 I HEREBY CERTIFY, That I attended deceased from 1-19- 1927, to 1-24- 1927, that I last saw h— alive on 1-24- 1927, and that death occurred, on the date stated above, at 3 15 p. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Grippe

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Hayward Stein M. D.

1927 (Address) 1111 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem Co

DATE OF BURIAL Jan 26 1927

UNDERTAKER F. B. Wellfint

ADDRESS 1850 N. Howard St

Spec.—7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18319

## CERTIFICATE OF DEATH

E 18319

REGISTERED NO. 1851

1-PLACE OF DEATH St Agnes Hospital

City of BALTIMORE: (No. 24 & Mt Olivet Lane St., 20th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Moses Athenison

(a) RESIDENCE NO. 24 Mt Olivet Lane St. 20th Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. 5 mos. 18 da. How long in U. S. if of foreign birth? yrs. mos. da.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Mal. | Black | Married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mrs Henriette Athenison

6 DATE OF BIRTH (month, day, and year) Aug 6th 1851

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min.. |
|---|---|---|---|---|
| | 75 | 5 | 18 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stock Dealer
(b) General nature of industry, business, or establishment in which employed (or employer)
(r) Name of employer

9 BIRTHPLACE (city or town) Balt Md
(State or country)

PARENTS

10 NAME OF FATHER Moses Athenison
11 BIRTHPLACE OF FATHER (City or town)
(State or country) England
12 MAIDEN NAME OF MOTHER Hannah Ogle
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) England

14 Informant Mrs Henriette Athenison
(Address)

Filed JAN 5 1927 C. HAMPSON JONES, M. D. Registrar
Per ARH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 19, 1927 to Jan 24 1927
that I last saw h[illegible] M alive on Jan 24 1927
and that death occurred, on the data stated above, at 1:20 A m.
The CAUSE OF DEATH was as follows:
Cerebral hemorrhage left
carotid sclerosis
(duration) yrs. mos 5 da.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. da.

18 Where was disease contracted
If not at place of death?
Did an operation precede death? Data of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W. P. Boyd, M. D.
. 19 (Address) 17 Upton Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Loudon Park Cemetery Date of Burial Jan 27 1927

20 UNDERTAKER H. S. Wiegand ADDRESS 1850 N Eutaw

Cor.—12-9-25—A Co—200 Bks. Delmont Station, Severn Md

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18320 — CERTIFICATE OF DEATH. — E 18320

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Kennedy Krause St. 4 30 Ward)

2-FULL NAME Leonard M. Breitschwerdt

(a) RESIDENCE NO. Delmont Severn Md St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yr. mos. / ds. How long in U. S., if of foreign birth? yr. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | W | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 11 1920

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 6 | 1 | 12 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER Edw Breitschwerdt

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary C Faust

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto Md

14 Informant Edward L Breitschwerdt

(Address) Delmont Severn Md

Filed ..... 1927 — C. HAMPSON JONES, M. D. — Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above, Railroad accident

The CAUSE OF DEATH* was as follows)

Accidental Death

Struck by B. & O. Train near Delmont Md

(duration) Instant yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Hamilton Owen M. D.

(Coroner)

, 19 27 (Address) 3325 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ..... mos., ..... ds. In the state ..... yrs., ..... mos., ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Date of Burial Jan 26 1927

20 UNDERTAKER William Cook ADDRESS 522 E North Ave

Spec.—12-9-25—A Co.—200 Blks. See letter on file from R Hooper Smith MD dated 2-3-27

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18321

CERTIFICATE OF DEATH.

12 E 18321

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

REGISTERED NO.

City of BALTIMORE: (No. [redacted] St. 17-51 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Kirkpatrick

(a) RESIDENCE NO. 420 Glenedwards St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if at foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): ~~Widowed~~ Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Kirkpatrick

6 DATE OF BIRTH (month, day, and year): ~~1857~~ 1873.

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 54 ~~84~~ | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer): Own

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Maryland

PARENTS

10 NAME OF FATHER: David Kirkpatrick

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Maryland

12 MAIDEN NAME OF MOTHER: Ella Haines

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): England

14 Interment (Address): Records

BALTIMORE CITY HOSPITALS

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): January 24/1927

17

I HEREBY CERTIFY, That I attended deceased from January 22, 1927, to January 24, 1927, that I last saw h~~im~~ alive on January 23, 1927, and that death occurred, on the date stated above, at 12 30 A m,

The CAUSE OF DEATH* was as follows:

Auricular Fibrillation

Myocardial Hypertrophy & Chronic Nephritis

Cirrhosis of the Liver

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary): Myocardial Failure

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes.

What test confirmed diagnosis? Gennaro Laboratory

(Signed) R. Hooper Smith, M. D.

Jan. 24 1927 BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths due to Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — Date of Burial: June 7 1927

20 UNDERTAKER: Wellman Bros — ADDRESS: 502 E Nat'l Ave

5 1927 Per [redacted] Registrar

Spec.—12-9-25—A Co.—200 Bks.

E 18322

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18322

## CERTIFICATE OF DEATH.

16-22-90

1-PLACE OF DEATH

City of BALTIMORE: (No. [redacted] St., 16 Ward)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John P. McKitrick

(a) RESIDENCE NO. 2006 Edmondson Ave St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | ? |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1871

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 56 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Lawrence McKitrick

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant

(Address) Records

15 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 24 1927

17

I HEREBY CERTIFY, That I attended deceased from August 24, 1926, to January 24, 1927, that I last saw him alive on January 24, 1927, and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Cortical Sclerosis

Chronic Myocarditis Influenza

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? general & Laboratory

(Signed) R. Thompson Smith, M. D.

Jan. 26 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

New Cathedral Jan 27 1927

20 UNDERTAKER ADDRESS

Wilbanks Bal 3026 Nathan

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18323 — 188-093 — E 18323

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St., 3 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rotzina Lyudymau Lyudemann

(a) RESIDENCE NO. 2439 First St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Lidemann

6 DATE OF BIRTH (month, day, and year)

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 68 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER: Wilhelm Brodyhaus

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Dorothea

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Baltimore

14 Informant: Ewa Brodhausen

(Address) 2742 Alunda Ave

15 Filed 1927 C. HAMPSON JONES, M. D.

Per ACH Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23 1927

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Auto Acc.

Multiple Fracture

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. C. Hudson M. D.

(Coroner)

(Address) 1431 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmell — Date of Burial 1/26/27

20 UNDERTAKER: J. Ahrens & Co — ADDRESS 3714 Penna

Spec.—12-9-25—A Co.—200 Bks.

E 18324

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18324

## CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospital St., ____ Ward)

2-FULL NAME Alexander Bauer

(a) RESIDENCE NO. 1004 McCulloh St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1873

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 54 ? | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 0 H 0

(c) Name of employer

9 BIRTHPLACE (city or town): Va

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town): Unknown

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town): Unknown

(State or country)

14 Informant: Hospital Record

(Address)

15 Date: Jan 25 1927 C. HAMPSON JONES, M. D.

Per _____ Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 Jan. 23,

17 I HEREBY CERTIFY, That I attended deceased from Jan. 13, 1927, to Jan 23, 1927, that I last saw him alive on Jan. 23, 1927, and that death occurred, on the date stated above, at 3:30 p.m.

The CAUSE OF DEATH* was as follows:

Bronco Pneumonia Septicemia
& Chronic Interstitial Nephritis

(duration) Unknown ds.

CONTRIBUTORY (Secondary) Senile Bronchitis

(duration) ....yrs. ....mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Course

(Signed) W. Kerr Russell, M. D.

, 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem. Date of Burial Jan 26, 27

20 UNDERTAKER: Samuel H. Buckley & Bro. ADDRESS 1728 E. Baltimore

Spec.—1-10-21—M&T—1500 Bks.

E 18325 HEALTH DEPARTMENT—CITY OF BALTIMORE 1001 E 18325

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1144 N. Strickers ST. 16-22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Murray

(a) RESIDENCE NO. 1144 N. Strickers ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth Murray

6 DATE OF BIRTH (month, day, and year) 1863

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 64 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Waiter

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Talbot Co. Md.

PARENTS

10 NAME OF FATHER: Harrison Murray

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Hutchinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Talbot

14 Informant (Address): Elizabeth Murray 1144 N Strickers St

15 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 23rd 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 11th 1927 to Jan 23rd 1927.

that I last saw h[illegible] alive on Jan 23rd 1927

and that death occurred, on the date stated above, at 6.20 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jas E. Bell, M. D.

, 19 (Address) 913 Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Laurel Cem | Jan 26 1927 |

20 UNDERTAKER: Leonard F Hemsley ADDRESS 578 W Baltimore

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18326

## CERTIFICATE OF DEATH.

1 29 E 18326

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 230 W Bruce ST. 1927 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Levi Tabb

(a) RESIDENCE NO. 230 W Bruce ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 50 ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | Colord | Married |

5a If married, widowed or divorced HUSBAND of (or) WIFE of Julia Ann Tabb.

6 DATE OF BIRTH (month, day, and year) April 16-1865

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 61 | 9 | 7 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter.

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer Gilpin Bros.

9 BIRTHPLACE (city or town) (State or country) King & Queen Co Va.

PARENTS

10 NAME OF FATHER William Tabb

11 BIRTHPLACE OF FATHER (city or town) K & Q. Co (State or country) Va.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Julia Ann Tabb (Address) 230 W Bruce St

15 Filed JAN 5 1927 Per C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec. 11, 1926, to Jan 23, 1927, that I last saw h~~e~~alive on Jan 23, 1927 and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Nephritis.
(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation
(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms & Typical

(Signed) W H Wright, M. D.

Jan 23, 1927 (Address) 1209 Pocahontas

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem DATE OF BURIAL Jan 26 1927

20 UNDERTAKER Samuel Hensley ADDRESS 678 Baddle

Spec.—6-9-19—H. P. Co.—1000 Bks.

18327

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18327

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Beechdale & 40th St.

CITY OF BALTIMORE: (No.) Wyman Park Apts (St.) 13-52 89 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lee Randolph Smith

(a) RESIDENCE. No. Wyman Park Apartments St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence E. Smith

6 DATE OF BIRTH (month, day, and year) Feb. 9-1864

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 62 | 11 | 21 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self.

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland.

PARENTS

10 NAME OF FATHER Nicholas M. Smith

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Mary E. King

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland.

14 Informant Samuel L. Smith (Address) Carlton Apts

15 Filed 1927 By C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23 1927

17 I HEREBY CERTIFY, That I attended deceased from January 4. 1927 to Jan. 23. 1927. that I last saw him alive on January 23. 1927. and that death occurred, on the date stated above, at 1.45 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency
Coronary Thrombosis
Angina Pectoris

(duration) yrs. mos. 23 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs.

(Signed) M. Gibson Porter, M. D.

1/24. 1927 (Address) 422 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Greenmount Cemetery | Jan 26 1927 |
| 20 UNDERTAKER | ADDRESS |
| Hughes & Jones Inc | 1 E. Preston |

Spec.—1-10-21—M&T—1500 Bks.

E 18328 HEALTH DEPARTMENT—CITY OF BALTIMORE E 18328

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1622 Druid Hill St. 14-20 Ward)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mamie Ryan

(a) RESIDENCE NO. 1622 Druid Hill ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Fe | Col | Widow |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of 5

6 DATE OF BIRTH (month, day, and year) [illegible] 1863

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or.....min. |
|---|---|---|---|---|
| 64 | 63 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Thaddeus Ryan

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Malinda —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant Mary Jenson
(Address) 1622 Druid Hill Ave

15 Filed 26 1927. 19 C. HAMPSON FORMAN, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1927, to Jan 24, 1927.
that I last saw h alive on Jan 23, 1927
and that death occurred, on the date stated above, at 3 A, m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. 2 mos 2 ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D H Cameron M. D.

1/25 19 27 (Address) 805 Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL Jan 26 1927

20 UNDERTAKER John H Loadenthal — ADDRESS 1037 Druid Hill Ave

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 18329

REGISTERED NO. 1-24 129

1-PLACE OF DEATH

City of BALTIMORE: (No. 540 Oxford St. 17 Ward)

(If death occurred in a Hospital or Institution, give NAME instead of street and number.) E 18329

2-FULL NAME Ora Holbrook

(a) RESIDENCE NO. 540 Oxford St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Everett Holbrook

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE: Years 32; Months; Days; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic service

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Virginia

PARENTS

10 NAME OF FATHER: Henry Johnson

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Va.

12 MAIDEN NAME OF MOTHER: Taylor

BIRTHPLACE OF MOTHER (city or town)

(State or country): Va.

14 Informant: Everett Holbrook

(Address): 540 Oxford St. Balto, Md.

JAN 26 1927 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/26/1927

17 I HEREBY CERTIFY, That I attended deceased from July 21 1926 to Jan. 23, 1927, that I last saw h.. alive on Jan 23, 1927, and that death occurred, on the date stated above, at 1:30 P m.

The CAUSE OF DEATH* was as follows)

Uremia

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) John H. Johnson M. D.

1/26/1927 (Address) 1019 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvary Date of Burial Jan 26 1927

20 UNDERTAKER: John H. Toadvine ADDRESS 1027 Druid Hill

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18330

## CERTIFICATE OF DEATH.

101-001

4-25

E 18330

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. ) St. 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Edward Hawkins

(a) RESIDENCE NO. 633 Redwood St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 30 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer (Odd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER John Hawkins

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant City Hospitals Records

(Address)

15 Filed ..... 19 ..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 21 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan. 19, 1927 to Jan. 21, 1927

that I last saw him alive on Jan. 21, 1927

and that death occurred, on the date stated above, at 1:30 A. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Gross & Sect.

(Signed) C. Holmes Engel, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Mt. Auburn Date of Burial Jan 26 19 27

20 UNDERTAKER John N. Toadvine ADDRESS 1027 Druid Hill

NOV 1927

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18331

## CERTIFICATE OF DEATH.

90 E 18331

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2036 Orleans St St. 6-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hyman Shorr

(a) RESIDENCE NO. 2036 Orleans St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widower |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gisha Shorr

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 80 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER Harry Shorr

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Dina -------

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Jack Lewis

(Address)

15 Filed JAN 26 1927 19 Per C. HARRY JONES M.D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24th 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation-Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility/Arteriosclerosis

(duration) yrs. mos. ds.

(Signed) J. H. Mace M. D.

(Coroner)

1/25/27 19 (Address) 505 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Date of Burial 1/26 1927

20 UNDERTAKER D. Jack Lewis ADDRESS 1439 E Balto St

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18332

## CERTIFICATE OF DEATH.

167-001

REGISTERED NO. E 18332

1-PLACE OF DEATH

City of BALTIMORE: (No. 2112 E. Baltimore St. 6-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosie Drapkin

(a) RESIDENCE NO. 2100 E. Baltimore St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Benj. Drapkin

6 DATE OF BIRTH (month, day, and year)

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 36 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 937

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant: Benj. Drapkin

(Address) 19 S. Exeter Street

15 [illegible] HAMPSON JONES, M. D.

JAN 26 1927

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-24- 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Illuminating Gas Asphixiation (Suicide)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. S. H. Culler M. D.

(Coroner)

1-25 1927 (Address) 508 E. North Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ..... mos., ..... ds. In the State ..... yrs., ..... mos., ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dortmen circle Cem Date of Burial 1/26 1927

20 UNDERTAKER Jack Levis ADDRESS 1439 Eden St

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 18333 — 1-PLACE OF DEATH — 117 — REGISTERED NO. E 18333

City of BALTIMORE: (No. St Agnes Hospital 46-67 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Winfield D Koontz Jr

(a) RESIDENCE NO. 2936 Mosher St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 11 1917

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min.. |
|---|---|---|---|---|
| | 9 yrs. | 5 | 11 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy. 00

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md (State or country)

PARENTS

10 NAME OF FATHER Winfred D Koontz

11 BIRTHPLACE OF FATHER (City or town) Balti- Md (State or country)

12 MAIDEN NAME OF MOTHER Vernon Cannon

13 BIRTHPLACE OF MOTHER (city or town) Bal- Md (State or country)

14 Informant Winfred D Koontz Sr (Address) 2936 Mosher St

15 Filed JAN 26 1927 19 C. HAMPSON JONES Registrar

For

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 19th 1927, to Jan 25th 1927, that I last saw h.... alive on Jan 25th 1927, and that death occurred, on the date stated above, at 12.20 A. m.

The CAUSE OF DEATH* was as follows:

Intraperitoneal hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Appendectomy

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? Yes Date of 1-17-27

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Theron Hunter M. D.

1/24 1927 (Address) St. Agnes' Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

New Cathedral Cemetery Jan 28 1927

20 UNDERTAKER — ADDRESS

John Ottenschell 1908 Eutaw Pl

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18334

## CERTIFICATE OF DEATH.

89

E 18334
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hopkins Apts. St. Paul St. 31. ST., 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gover C. Houser

(a) RESIDENCE No. Hopkins Apts ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Caroline Louise Houser

6 DATE OF BIRTH (month, day, and year) July 20. 1868

7 AGE

| Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|
| 58 | 6 | 3 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Hat 66

(b) General nature of Industry, business, or establishment in which employed (or employer): Salesman

(c) Name of employer: Baltimore Md

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Gassaway S. Houser

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Cecelia Bromwell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Caroline L. Houser
(Address): Hopkins Apts

15 ~~C. HAMPSON JONES, M. D.~~
Register

JAN 26 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 23 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1926. to Jan. 23 1927.

that I last saw him alive on Jan 23 1927.

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Angina pectoris

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) (coronary) arteriosclerosis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of /

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Frederick Bailey, M. D.

19 (Address) Temple Gardens

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: January 26 1927

UNDERTAKER: Chas. Ortwein & Son

ADDRESS: 1201 W. Fayette St

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18335 E 18335

## CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 524 St. Paul ST. 16-26 WARD)

2-FULL NAME Emelie Schmidt born

(a) RESIDENCE No. 524 St Paul ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. 70 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Femal | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emil Schmidt born

6 DATE OF BIRTH (month, day, and year) Aug 11 1856

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 70 | 5 | 12 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER John Uhrig

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Nellie Hoffman

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Mrs Ann Uhrig

(Address) 644 W Franklin

15 Filed JAN 26 1927, 19 Registrar

C. HAMPSON JONES, M.D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 19, 1927, to Jan 23, 1927, that I last saw he alive on Jan 22, 1927, and that death occurred, on the date stated above, at 5.30 p.m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 2 mos. 4 ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) John H Crans, M. D.

, 19 (Address) 612 W 40th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount

DATE OF BURIAL Jan 26 1927

20 UNDERTAKER C. Hampson Jones, M.D.

ADDRESS Baltimore, Md.

Spec.—12-9-25—A Co.—200 Bks.

E 18336

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 18336

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 935 Booth St. 18-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matilda Murray

(a) RESIDENCE NO. 935 Booth St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 Color or Race: Col'd

5 Single, Married, Widowed, or Divorced, (write the word): Wid

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1861

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 66 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (City or town): Wash City

(State or country)

PARENTS

10 NAME OF FATHER: James Ervin

11 BIRTHPLACE OF FATHER (city or town)

(State or country) md

12 MAIDEN NAME OF MOTHER: Ann Jenson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) md

14 Informant: Thos Lowe

(Address) 935 Booth St

15 Filed ..., 19.. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 23/27 19

17 I HEREBY CERTIFY, That I attended deceased from Nov 20 1926 to Jan 23, 1927, that I last saw h... alive on Jan 22, 1927, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows: Organic Disease of Heart

(duration) ...yrs. 2 mos. ...ds.

CONTRIBUTORY (Secondary): Pulmonary Oedema

(duration) ...yrs. ...mos. 1 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H Norwood, M. D.

Jan 28 1927 (Address) 939 N Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem Date of Burial Jan 26 1927

20 UNDERTAKER: Daniel Carter ADDRESS 916 64 mc

Cor.—1-12-23—M&T—100 Bks.

E 18337

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18337 1927 41 1886

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1318 N Carey ST. 15-23/14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Faulkner

(a) RESIDENCE NO 1318 N. Carey St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | Colored | Married |

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Mollie Faulkner.

DATE OF BIRTH (month, day, and year) Jan 29 1886

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| 40 41 | 41 | 11 | 29 | |

OCCUPATION OF DECEASED 040

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Labor (General)

BIRTHPLACE (city or town) (State or country) Seth Boston Va.

10 NAME OF FATHER Thomas Faulkner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Lethia Wyatt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

Informant Mrs Mollie Faulkner

(Address) 1318 Brenford

Filed 1927 HARRISON JONES M. D.

126152 RK Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 24, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an enquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said enquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

acute gastro-enteritis 5 da

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) acute dilatation of heart 5 minutes

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy, M. D. (Coroner.)

Jan 25, 1927 (Address) 202 Hennessy Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Seth Boston Va. DATE OF BURIAL Jan 27 1927

20 UNDERTAKER Samuel Wright ADDRESS 1516 Mary

Spec.—1-12-23—M&T—500 Bks.

E 18338 HEALTH DEPARTMENT—CITY OF BALTIMORE E 18338

# CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1521 Park Ave ST 14-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Buck Irwin

(a) RESIDENCE NO. 1521 Park Ave ST., WARD St Louis

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 3 mos. 0 ds. How long in U. S., if of foreign birth? 50 yrs. 11 mos. 7 ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Feb. 16th. 1876

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 50 | 11 | 7 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Berryville Va.
(State or country)

PARENTS

10 NAME OF FATHER Marcus Irwin

11 BIRTHPLACE OF FATHER (city or town) Berryville
(State or country) Va.

12 MAIDEN NAME OF MOTHER Julia Buck

13 BIRTHPLACE OF MOTHER (city or town) Berryville
(State or country) Va.

14 Informant Mr. J.B. Harmeberger (Brother in Law)
(Address) 1521 Park Ave

15 Filed 1-26 1927 C. HARRY JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25th 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov, 1926, to Jan 25, 1927,

that I last saw her alive on Jan 25th, 1927,

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

Unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Anaemia (Pernicious?)

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X Ray

(Signed) Jefferies Ames, M. D.

1/26 1927 (Address) 2844 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Berryville Va.

DATE OF BURIAL Jan. 27 1927

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor)

ADDRESS 108 W. NORTH AVE

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18339

## CERTIFICATE OF DEATH

74-001

E 18339

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1342 N Bond St., 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Junius Smith Wright

(a) RESIDENCE NO. 1342 N Bond St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. ~ mos. ~ ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widowed |

5a If married, widowed, ~~or divorced~~ HUSBAND of ~~(or) WIFE of~~ Linda S. Wright

6 DATE OF BIRTH (month, day, and year) January 15, 1851

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..hrs. or ..min.. |
|---|---|---|---|---|
| | 76 | 9 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) Virginia

(State or country)

PARENTS

10 NAME OF FATHER Nicholas Wright

11 BIRTHPLACE OF FATHER (City or town) Not Known

(State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known

(State or country)

14 Informant Frank R. Williams

(Address) 1342 N Bond St

Filed JAN 26 1927 Registrar

C. HAMPSON JONES, M. D.

For

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JAN 24 1927 19

17 I HEREBY CERTIFY, That I attended deceased from January 19 27, to January 24 19 27.

that I last saw h~~e~~r alive on January 24 19 27

and that death occurred, on the date stated above, at 8 10 ~~P.~~ M. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

~~Contributory~~

(duration) 4 yrs. ~ mos. ~ da.

CONTRIBUTORY Cattle Tuberculosis

(Secondary) Cerebral Hemorrhage

(duration) ~ yrs. ~ mos. 5 da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) C. Hampson Jones, M. D.

Jan 26 1927 (Address) 1328 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Scotland Track, N. C. Date of Burial JAN 27 1927 19

20 UNDERTAKER Geo W Little ADDRESS 2708 MADISON AVE.

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18340

## CERTIFICATE OF DEATH

+ 108

E 18340

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. 430 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo. E. French

(a) RESIDENCE NO. Same St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida. H. French

6 DATE OF BIRTH (month, day, and year) July 28 — 1870

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|---|
| | 56 | 5 | 28 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Undertaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md

PARENTS

10 NAME OF FATHER James French

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Lee

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Hospital Record

(Address)

Filed 1926 HAMPSON JONES, M. D. Registrar

1 26 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1927

17 I HEREBY CERTIFY, That I attended deceased from June 22, 1926, to June 25, 1927, that I last saw h.. alive on June 25, 1927, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows: Cardiac Insufficiency

(duration) yrs. mos 3 da.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos da.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? Yes Date of 11/24/26

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Post

(Signed) H. M. Hook M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Md

Date of Burial 11/29/26

20 UNDERTAKER E. D. Hale

ADDRESS 1156 E Balto Md

Taylor

Spec.–7-17-26—A Co.—200 Bks.

E 18341

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

119 E 18341

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hospital St. 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Taylor

(a) RESIDENCE NO. 1409 Mosher Street St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Colored | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 44 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (1)

(State or country) Va

PARENTS

10 NAME OF FATHER Tony Cooper

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Lenthan Tasser

(Address) 1409 Mosher Street

15 Filed JAN 26 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 Jan 23, 1927

17 I HEREBY CERTIFY. That I attended deceased from Jan 22, 19 27, to Jan 23, 19 27,

that I last saw h alive on Jan 23, 19 27,

and that death occurred, on the date stated above, at 5 25 P m.

The CAUSE OF DEATH* was as follows:

Intestinal Hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Hepatic Abscess

(duration) yrs. mos. 14 ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab.

(Signed) F Kreeb M. D.

Jan 23, 19 27 (Address) 1122 N Mount St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem

Date of Burial Jan 26 19 27

20 UNDERTAKER Leonard Whalen

ADDRESS 30 Martin Ave

Cor.—12-9-25—A Co.—200 Bks.

Keffer.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18342

## CERTIFICATE OF DEATH.

E 18342

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Sq. Hospital St., Ward 19)

REGISTERED NO. 1927

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ralph P. Keffer Jr.

(a) RESIDENCE NO. 1621 W. Fayette St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day and year) Dec 24th 1923

7 AGE: Years 3 Months 1 Days 1 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country)

PARENTS

10 NAME OF FATHER Ralph P. Keffer

11 BIRTHPLACE OF FATHER (city or town) Va

(State or country)

12 MAIDEN NAME OF MOTHER Virgie Pierce

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) N C

14 Informant Ralph P. Keffer Sr

(Address) 1621 W. Fayette

FEB 6 1927 19 C. HAMPSON JONES, M. D.

By R. H. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest / Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest / Inquiry and from Inquest / autopsy / inquiry find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

2nd Degree accidental burns of body

(duration ..... yrs. ..... mos. ..... ds.)

CONTRIBUTORY (Secondary) Shock

(duration ..... yrs. ..... mos. ..... ds.)

(Signed) Thos. B. Horton M. D.

(Coroner)

Jan 25. 1927 (Address) Curtis Bay, Balto Md

*State the Disease Causing Death, or in deaths from Violent causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See rules for additional data.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet — Date of Burial Jan 27 1927

20 UNDERTAKER George J Smith — ADDRESS 153 [illegible]

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 18343
1-PLACE OF DEATH

× 113

E 18343
REGISTERED NO.

City of BALTIMORE: (No. So. Balto. Gen. Hosp 24-34 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rudolph Charles Urban Jr

(a) RESIDENCE NO. 1809 Light St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. 4 mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | White | SINGLE |

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 11, 1926

| 7 AGE | Years | Months | Days | If LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | | 4 | 14 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Glenburnie Md.
(State or country)

PARENTS

10 NAME OF FATHER Rudolph C. Urban Sr.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mabel Pumphrey

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Glenburnie Md.

14 Informant Mrs Mabel Urban
(Address) 1809 Light St.

15 Filed ..... 19 .....
Per ..... Registrar.

C. HARRY JONES, M. D.

26 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19
JANUARY 25, 1927.

17 I HEREBY CERTIFY, That I attended deceased from JAN 24, 19 27, to JAN 25, 19 27, that I last saw h.i.m. alive on JAN. 25, 19 27, and that death occurred, on the date stated above, at 9:30 A m.

The CAUSE OF DEATH* was as follows:

ACUTE GASTRO ENTERITIS

(duration) yrs. mos. 1 ds.

CONTRIBUTORY MALNUTRITION
(Secondary)

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? HOME

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? SIGNS & SYMPTOMS

(Signed) James E Peterman, M. D.

, 19 (Address) 1278 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Cedar Hill Cem. Jan. 26 19 27

20 UNDERTAKER — ADDRESS

Margaret G. Flynn 417 Light St.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18344

## CERTIFICATE OF DEATH

122-002 E 18344

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 33 Birchhead St. 23-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine W. Ruffer

(a) RESIDENCE NO. 33 Birchhead St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John J. Ruffer

6 DATE OF BIRTH (month, day, and year) aug 25 1890

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 36 | 4 | 29 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Boston, Mass.

(State or country)

PARENTS

10 NAME OF FATHER John Stone

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Halifax N.S.

12 MAIDEN NAME OF MOTHER Mont Munro

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Halifax N.S.

14 Informant John J. Ruffer

(Address) 33 Birchhead St.

15 Filed JAN 26 1927 16 HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1926 to Jan 24, 1927

that I last saw h... alive on Jan 24, 1927

and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma (Cervix) of Rectum

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Clinically

What test confirmed diagnosis

(Signed) Alex Campbell M. D.

Jan 26 1927 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Holy Cross Cem Co. | Jan 27 1927 |
| 20 UNDERTAKER Margaret A. Flynn | ADDRESS 1422 Light St |

Spec.—1-10-21—M&T—1500 Bks.

Agnes Mary Stickler

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18345

## CERTIFICATE OF DEATH.

E 18345

REGISTERED NO. 26-429

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3 Cole Avenue Raspeburg ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Mary Stickler

(a) RESIDENCE NO. 3 Cole Avenue Razneburg ST., 26 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of Mr. Martin J. Stickler

6 DATE OF BIRTH (month, day, and year) August 27, 1875

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 51 | 5 | 28 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Joserh W. Haid

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Wilhelmina Knockey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Martin J. Stickler (Address) 3 Cole Avenue

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 25, 1927

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1926 to January 25, 1927.

that I last saw h or alive on January 24, 1927.

and that death occurred, on the date stated above, at 1:40 A. m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis with Hypertension.

(duration) Many yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? O Date of

Was there an autopsy?

What test confirmed diagnosis?

Signed A. L. Wilkinson, M. D.

1/25/27 A. L. Wilkinson

19 (Address) 13 N. Belair Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL Jan. 28 1927

20 UNDERTAKER Henry Storck Son

ADDRESS 1201 E Eager St

JAN 26 1927 E. HAMPSON JONES, M. D. Registrar

Dep R K

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18346

## CERTIFICATE OF DEATH.

90 E 18346

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Josephs Hospital

CITY OF BALTIMORE: (No. Caroline & Oliver ST. 35 WARD)

2-FULL NAME Thomas Consolvo.

(a) RESIDENCE NO. 113 Albemarle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? 22 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Consolvo

6 DATE OF BIRTH (month, day, and year): June 16 1875

7 AGE: Years 51; Months 7; Days 9; If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer. U.R.R.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Domenck Consolvo

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Antonetta

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant (Address): Antonetta Pasmo 113 Albemarle

15 Filed JAN 26 1927 C. HAMPSON JONES, M.D. Registrar

For R.H.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 25 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 25, 1927, to Jan 25, 1927, that I last saw h[illegible] alive on Jan 25, 1927, and that death occurred, on the date stated above, at 10:45 a.m.

The CAUSE OF DEATH* was as follows:

Hypertension.
Cardio. nephritis.
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Cerebral. Hemorrhage.
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? none

What test confirmed diagnosis? Clinical.

(Signed) H. R. McConnell, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Jan 27 1926

UNDERTAKER: Wendell Offel Son — ADDRESS: 378 Mmm

Spec.—12-9-25—A Co.—200 Bks.

# E 18347 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 E 18347

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. 2179 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard Brosseker

(a) RESIDENCE NO. 914 Ramsay st. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Brosseker

6 DATE OF BIRTH (month, day, and year) 1881

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| 46 | 45 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER George Brosseker

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Hagemann

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant Hospital Records

(Address)

Filed JAN 26 1927 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 January 25, 1927

17 I HEREBY CERTIFY, That I attended deceased from November 4, 1926, to January 25, 1927, that I last saw h.. alive on January 25, 1927, and that death occurred, on the date stated above, at 2.35 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) W. E. Gallenz, M. D.

19 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

London Park Cem. Jan 28 1927

20 UNDERTAKER ADDRESS

Jos Joerdens Son 2178 Pa

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18348

## CERTIFICATE OF DEATH.

74-001

E 18348

REGISTERED NO.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St., 9-46 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Knowles

(a) RESIDENCE NO. 2741 Almeda Blvd St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1864

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 63 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER James Knowles

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Hannah –

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant [redacted]

(Address) Records

Jan 26 1927

Jan 29 1927

C. HAMPSON JONES, M. D.

RKR Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 25 1927

17 I HEREBY CERTIFY, That I attended deceased from April 6, 1926, to January 25, 1927, that I last saw him alive on January 24, 1927, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Cortical Sclerosis

Typhoid Fever

(duration) 2 yrs. mos. ds.

CONTRIBUTORY Cerebral Hemorrhage

(Secondary)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? general & laboratory

(Signed) R. Hooper Smith, M. D.

Jan 25 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Baltimore Cemetery Jan 28 1927

20 UNDERTAKER — ADDRESS

Henry Lutz 1203 N Broadway

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18349 E 18349

## CERTIFICATE OF DEATH.

REGISTERED NO. 2459 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2407 Brookfield Ave (STREET) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Donel Hanrahan

(a) RESIDENCE NO. 2407 Brookfield Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced (of) WIFE of John W Hanrahan

6 DATE OF BIRTH (month, day, and year): July 10-1897

7 AGE: Years 29 Months 6 Days 15 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Whuling W. Va.

PARENTS

10 NAME OF FATHER: Chas O Rosmar

11 BIRTHPLACE OF FATHER (city or town) (State or country): W. Va.

12 MAIDEN NAME OF MOTHER: Sarah P Sweeney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): W. Va.

14 Informant (Address): John W Hanrahan 2407 Brookfield Ave

15 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1-25 1927

17 I HEREBY CERTIFY, That I attended deceased from 1-23- 1927 to 1-25 1927

that I last saw h alive on 1-25 1927

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic valvular disease of heart - Myocardial insufficiency

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Infarct

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) S. Ormand M. D.

1-26 1927 (Address) 1604 Linden ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemet Washington D.C. DATE OF BURIAL: Jan 27 27

20 UNDERTAKER: A J Aske ADDRESS: Glenburnie

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18350

E 18350

CERTIFICATE OF DEATH

1927 Q 476

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm Moore

(a) RESIDENCE NO. 1433 Gorsuch St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Cecelia T. Moore

6 DATE OF BIRTH (month, day, and year): Feb. 2 - 1857

7 AGE: Years 75 Months 11 Days 22 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Attorney at Law

(b) General nature of industry, business, or establishment in which employed (or employer): Self

(c) Name of employer

9 BIRTHPLACE (city or town): England

(State or country)

PARENTS

10 NAME OF FATHER: Thomas Moore

11 BIRTHPLACE OF FATHER (city or town): Ireland

(State or country)

12 MAIDEN NAME OF MOTHER: Mary Dempsey

13 BIRTHPLACE OF MOTHER (city or town): Ireland

(State or country)

14 Informant: Cecelia T. Moore

(Address) 1435 Gorsuch Ave

15 Jan 26 1927 C. HAMPSON JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 24 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Femur

Fracture tibia - Comp

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bron-Pneumonia

(duration) yrs. mos. ds.

Jan 26 - 1927 (Signed) W. J. Peters (Coroner)

(Address) 1639 Ruxton Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State 60 yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery Date of Burial 1/27 1927

20 UNDERTAKER: Chas F. Tracy & Son ADDRESS 1128 W. Mt Royal Ave

Spec.—1-10-21—M&T—1500 Bks.

E 18351

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18351

## CERTIFICATE OF DEATH.

114

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2531 McHenry St., (ST.) 20-69 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva E. Heinz,

(a) RESIDENCE NO. 2531 McHenry St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph J. Heinz

6 DATE OF BIRTH (month, day, and year) Dec. 25, 1884

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 42 | | 29 30 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hungary

PARENTS

10 NAME OF FATHER John Robb.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria, Hungary,

12 MAIDEN NAME OF MOTHER Heinz,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria Hungary

14 Informant Joseph J. Heinz,

(Address) 2531 McHenry St.

15 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 24 1927

17

I HEREBY CERTIFY, That I attended deceased from Jany 6, 1927, to Jany 24, 1927.

that I last saw h[illegible] alive on Jany 24, 1927.

and that death occurred, on the date stated above, at 4.30 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Gastro Enteritis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Angelar Nice M. D.

1/26, 1927 (Address) 1509 W Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL Jan. 27, 1927

20 UNDERTAKER Harry A. Witzke

ADDRESS 931 W. Lombard St

Cor.--12-9-25—A Co.—200 Bks.

E 18352

# HEALTH DEPARTMENT—CITY OF BALTIMORE

66 E 18352

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 207 Boston St. 1-3 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Wiley

(a) RESIDENCE NO. 207 Boston St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) ? ? 1889

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 38 | ? | ? | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER George Wiley

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore

12 MAIDEN NAME OF MOTHER Frances Abendschein

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore

14 Informant George A. Wiley (Brother)

(Address) 105 N. Kenwood Ave.

15 Dec 6 1927 For C. HAMPSON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Jan 25 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Alcoholism

(duration) yrs. mos. 30 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

Jan 25/27 (Signed) C. E. Wade M. D.

(Coroner)

(Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: First Evangelical Cemetery — Date of Burial: Jan 27 1927

20 UNDERTAKER: Henry Sander & Sons Inc — ADDRESS: 1710 Fleet St.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18353

## CERTIFICATE OF DEATH.

E 18353

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. _____ St., 16-21 57 Ward)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Norwell

(a) RESIDENCE NO. BALTIMORE CITY HOSPITALS St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widowed |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1867

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 60 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gardner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Delaware

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country)

14 Informant _____

(Address) Records

15 Date 6 1927 C. HAMPSON JONES, M. D. Registrar

6980

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 23 1927

17

I HEREBY CERTIFY, That I attended deceased from September 4, 1926, to January 23, 1927, that I last saw h[illegible] alive on January 23, 1927, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) ? yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ____ yrs. ____ mos. 3 ds.

18 Where was disease contracted

If not at place of death? _____

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis? General & Labratory

(Signed) G. Hooper Lull, M. D.

Jan 26 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL. Date of Burial 19

20 UNDERTAKER Commissioner Health. ADDRESS JAN 26 1927

Per E. P. WOODALL

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18354

## CERTIFICATE OF DEATH.

161-001

E 18354

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1031 N. Eutaw St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Ward

(a) RESIDENCE NO. 1031 N. Eutaw St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Negro

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 26 1927

7 AGE: Years | Months | Days | IF LESS than 1 day 6 hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: do

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md

PARENTS

10 NAME OF FATHER: Hoyle Ward

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Ala

12 MAIDEN NAME OF MOTHER: Victoria Shields

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): NC

14 Informant: Hoyle Ward

(Address): 1031 N. Eutaw

15 Filed ... 1927 G. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: Jan 26 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 26, 1927, to Jan 26, 1927, that I last saw h[illegible] alive on Jan 26, 1927, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Smoke, M. D.

1-26, 1927 (Address) 1126 Druid Hill

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL Date of Burial 19 JAN 26 1927

20 UNDERTAKER ADDRESS

Commissioner Health.

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18355

## CERTIFICATE OF DEATH

REGISTERED NO. E 18355

1-PLACE OF DEATH Church Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. Lombard & Eutaw St. Ward)

2-FULL NAME James Green

(a) RESIDENCE NO. Granite St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 23 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lara Green

6 DATE OF BIRTH (month, day, and year) 1865

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..hrs. or ..min.. |
|---|---|---|---|---|
| 61 | 62 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Trackman

(b) General nature of industry, business, or establishment in which employed (or employer) B & O

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland

(State or country)

PARENTS

10 NAME OF FATHER Thomas Green

11 BIRTHPLACE OF FATHER (City or town) md.

(State or country)

12 MAIDEN NAME OF MOTHER Laura Dorsey

13 BIRTHPLACE OF MOTHER (city or town) md.

(State or country)

14 Informant Hospital Records

(Address)

15 Filed JAN 26 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24 1927

17 I HEREBY CERTIFY, That I attended deceased from 12-3-26, to 1-26-27,

that I last saw h alive on 1-26-27,

and that death occurred, on the date stated above, at 11:40 a.m.

The CAUSE OF DEATH* was as follows:

Aplastic Anemia

Fractured Pelvis

(duration) yrs. 1 mos. 24 ds.

CONTRIBUTORY (Secondary) Fracture Thoracic Process (Dorsal)

(duration) yrs. mos. 5 ds.

18 Where was disease contracted Accident

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X Ray

(Signed) N B Sanders, M. D.

(Address) Church Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Cherry Hill Md Jan 19 27

20 UNDERTAKER ADDRESS

Easton Sons Elkton Md

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18356

## CERTIFICATE OF DEATH.

100-001

E 18356

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 515 N. Belnord Ave St. 7-10 Ward)

2-FULL NAME Crescentia C. Tragreser

(a) RESIDENCE NO. 515 N. Belnord Ave St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | white | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George J. Tragreser

6 DATE OF BIRTH (month, day, and year) July 6/1886

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 40 | 6 | 19 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Athome

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) Balto., Md

PARENTS

10 NAME OF FATHER Nicholas Faulstick

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Germany

12 MAIDEN NAME OF MOTHER Annie M. Schuchart

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Pa.

14 Informant Geo. J. Tragreser

(Address) 515 N. Belnord St.

6 1927 C. HAMPSON JONES, M. D.

Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25/1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocardial Failure

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Prob. bronchopneumonia

(duration) .....yrs. .....mos. 14 ds.

(Signed) Jos. H. Pallen, M. D.

(Coroner)

1/26/27 (Address) 508 E. Northave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?_____

Former or usual residence_____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery Date of Burial Jan 29 1927

20 UNDERTAKER Henry Storck Son ADDRESS 1301 E. Fayette St

Spec.—1-10-21 M&T 1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18357

## CERTIFICATE OF DEATH.

E 18357

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5 S Green St. (Ward) 30

2-FULL NAME Mary Refsneider

(a) RESIDENCE No. 5 S Green St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 7 1850

| 7 AGE Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|
| 76 | 1 | 27 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Johne Refsneider

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Mary Reifsneider

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Gertrude Hargrake (Address) 55 Green St Green

15 Filed Jan 26 1927 C. HAMPSON JONES, M. D. Registrar

Fee ——— apbs ———

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 25, 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 24, 1927, to Jan 25, 1927, that I last saw h alive on Jan 24, 1927, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

1 Broncho — Pneumonia

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mns. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Henry Ch. Bayley M. D.

Jan 26, 1927 (Address) 2805 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westlawn Cem. DATE OF BURIAL Jan 27, 1927

20 UNDERTAKER Lane Eaton ADDRESS 1 Jan 96

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18358

# CERTIFICATE OF DEATH

E 18358

1-PLACE OF DEATH University Hospital

REGISTERED NO.

City of BALTIMORE: (No. Lombard & Greene Sts 4-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. Spealman

(a) RESIDENCE NO. Randalstown Md Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word). |
|---|---|---|
| Male | white | Divorced |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence Spealman

6 DATE OF BIRTH (month, day, and year) July 17, 1867

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 59 | 6 | 8 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Conrad Spealman

11 BIRTHPLACE OF FATHER (City or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Annie Subock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Amelia Leuze

(Address) Randallstown, Md.

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Fee

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/25/27

17 I HEREBY CERTIFY, That I attended deceased from 1/23/27, 19..., to 1/25/27, 19...,

that I last saw him alive on 1/25/27, 19...,

and that death occurred, on the date stated above, at 4:15 P. M.

The CAUSE OF DEATH* was as follows:

Toxemia

Strangulated hernia

Gangrene & perforation

Diphtheria (duration) Peritonitis 1 wk. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 12 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? yes Date of 1/24/27

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) J. S. Winstead, M. D.

1/25, 1927 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem. Roslyn Md

Date of Burial Jan 27 1927

20 UNDERTAKER Joseph B. Cook

ADDRESS 1003 N. Gilmor St

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18359 | E 18359

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1505 McHenry ST. 19-28 WARD) REGISTERED NO. 74

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Senny Barnstricker

(a) RESIDENCE NO. 1505 McHenry ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jesse I. Barnstricker

6 DATE OF BIRTH (month, day, and year) Feb. 7, 1850

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 76 | 11 | 14 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Co., Md.

PARENTS

10 NAME OF FATHER John Metz,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick Co., Md.

12 MAIDEN NAME OF MOTHER Anne Shelton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Charles F. Barnstricker (Address) 1505 McHenry St.

Filed Jan 28 1927. C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 25 1927

17 I HEREBY CERTIFY, That I attended deceased from Jany 10, 1927, to Jany 25, 1927, that I last saw h[illegible] alive on Jany 24, 1927, and that death occurred, on the date stated above, at 12.05 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (apoplexy) (duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. A. O'Neill, M. D.

Jan 25 1927 (Address) 105 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL Jan. 28, 1927

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 W. Balto St.

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18360 — 74-001 — E 18360

## CERTIFICATE OF DEATH.

18-26

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 871 West Fayette ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Franklin Cooper

(a) RESIDENCE NO. 871 West Fayette ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha McGee Cooper

6 DATE OF BIRTH (month, day, and year) Mar.19,1837

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 89 | 10 | 7 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER James Cooper

11 BIRTHPLACE OF FATHER (city or town) Chester (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Susanna Marley

13 BIRTHPLACE OF MOTHER (city or town) Philadelphia (State or country) Pennsylvania

14 Informant Miss Caroline M. Cooper (Address) 871 west Fayette Street

15 Filed 6 1927, 19 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan.26, 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1927, to Jan 26, 1927, that I last saw him alive on Jan 26, 1927, and that death occurred, on the date stated above, at 12.30 p m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY (Secondary) Pulmonary Oedema (duration) yrs. mos 10 ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

Jan26 1927 (Address) 939 West Fayette Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL Jan.29, 1927

20 UNDERTAKER Joseph B Cook — ADDRESS 1003 N Eutaw St

Spec—12-23-21—E.B.R.S.—400 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18361

E 18361

## CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

City of BALTIMORE (No. 102 E. East Hamburg St. 24-33 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. George A. Reed

(a) Residence No. 102 East Hamburg St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

6a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Ann J. Reed

6-DATE OF BIRTH (month, day and year) March 12, 1842

7-AGE. 84 yrs. 10 mos. 14 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Harry M. Reed

(Address) 102 E. Hamburg

15- 2-6 1927 192 C. HAMPSON JONES, M. D. Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 26, 1927

17- I HEREBY CERTIFY, That I attended deceased from Jan 12, 1927 to Jan 26, 1927 that I last saw h[illegible] alive on Jan 25, 1927 and that death occurred, on the date stated above, at 11.50 A m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease.

(Duration) 1 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Bronchitis

(Duration) 0 yrs. 0 mos. 14 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry F. Buettner, M. D.

, 19 (Address) 1319 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Cross U.A.C.

DATE OF BURIAL 1/28 19

20-UNDERTAKER Wm Cook

ADDRESS 502 E North-

Spec.-7-17-26—A Co.—200 Bks.

(Proc 1)

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 18362

# CERTIFICATE OF DEATH

E 18362

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 706 N. Monroe St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eugene G. Preder

(a) RESIDENCE NO. 706 N. Monroe St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widowed |

5a If ~~married~~, widowed, or ~~divorced~~ HUSBAND of (~~or WIFE of~~) Anna Elizabeth

6 DATE OF BIRTH (month, day, and year) Dec 10 1854

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 72 | 1 | 15 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General natore of indostry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Mass.

PARENTS

10 NAME OF FATHER Fr. Preder

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Mass

12 MAIDEN NAME OF MOTHER Catherine Lynn

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Mass

14 Informant Edward F. Preder

(Address) 723 N. Collington

15 Filed 1927 Registrar C. HAMPSON JONES M. D.

For AKD

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 25 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 21 1927 to Jan 25 1927

that I last saw him alive on Jan 25 1927

and that death occurred, on the date stated above, at 6-30 P m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Data of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Cook M. D.

1/26 1927 (Address) 4007 Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Matthews — Date of Burial Jan 28 1927

20 UNDERTAKER Upton Cook — ADDRESS

Spec.—7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18363

## CERTIFICATE OF DEATH

11-001

E 18363

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2304 E Biddle St. 1-12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank L Kane

(a) RESIDENCE NO. 2304 E Biddle St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sadie Kane

6 DATE OF BIRTH (month, day, and year) June 9, 1893

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|---|
| | 33 | 7 | 15 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Eagle Cotton Products Co

9 BIRTHPLACE (city or town) Balto

(State or country) Md

PARENTS

10 NAME OF FATHER Thomas Kane

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Sydie Stuart

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Mrs Sadie Kane

(Address) 2304 E Biddle St

15 Filed 6 1927, 19

C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1927

17 I HEREBY CERTIFY, That I attended deceased from 1-21, 1927, to 1-24, 1927, that I last saw him alive on 1-24, 1927, and that death occurred, on the date stated above, at 6 1 m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

Following La grippe 3

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Tentative

(Signed) Thos L Rumbley M. D.

(Address) 800 N Patterson Pk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Baltimore Cem | Jan 27 1927 |

20 UNDERTAKER W. M. Cook

ADDRESS 527 E Monument

Very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18364

## CERTIFICATE OF DEATH.

21-31 188-003

E 18364

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital. St. _____ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Watkins.

(a) RESIDENCE NO. 624 N. Cross St. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male. | White. | Single. |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 70 | ---------- | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Watkins.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Elizabeth. -----

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore, Md.

14 Informant Lydia Wallace. (niece)

(Address) 624 N. Cross St.

6 1927 C. HAMPSON JONES, M. D.

By _____ Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 23, 1927. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal injuries.

Struck and knocked down by automobile.

Accidental Death.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....ds.

(Signature) Otto M. Leonhardt M. D.

(Coroner)

1/26 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death? Ostend & Leadenhall Sts. Jany. 21, 1927,

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem. Date of Burial 1/27 1927

20 UNDERTAKER Wm. Cook William Cook ADDRESS 502 S. Monroe

Spec.—12-9-25—A Co.—200 Pks.

E 18365

# HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 18365

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. _____ St., 5-7 Ward)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Francis

(a) RESIDENCE NO. 1745 N. Bond St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | white | Widower |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1847

| 7 AGE About | Years 80 | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Jesse M. Francis

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Scotland

12 MAIDEN NAME OF MOTHER Catharine Brooks

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Scotland

14 Informant

(Address) Records

15 Filed JAN 27 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 25 1927

17

I HEREBY CERTIFY, That I attended deceased from November 30, 1926, to January 25, 1927, that I last saw h.im alive on January 24, 1927, and that death occurred, on the date stated above, at 5.30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis 2 Insufficiency

Senility

Cerebral Sclerosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY Bronchopneumonia

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? general & laboratory

(Signed) C. Hooper Smith, M. D.

Jan 25 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. Date of Burial 1/27/27, 19

20 UNDERTAKER George J. Ruth ADDRESS 1735 Harford Ave

Spec.—1-12-23—M&C—500 Bks.

9 8 7 Dec 7

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18366

## CERTIFICATE OF DEATH.

5/ E 18366

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE: (No. ... ST. 2nd WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Smith

(a) RESIDENCE NO. 122 S. Chapel ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1916.

7 AGE: Years 11 | Months | Days | If LESS than 1 day, hrs. or min. | 10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md -

PARENTS

10 NAME OF FATHER: Will Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md -

12 MAIDEN NAME OF MOTHER: Cora Banks

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa -

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JAN 27 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 24 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 28, 1926, to Jan 24, 1927, that I last saw him alive on Jan 24, 1927, and that death occurred, on the date stated above, at 1500 p. m.

The CAUSE OF DEATH* was as follows:

Rheumatic endocarditis and myocarditis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Thomas N. Cornwall M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel cemetery — DATE OF BURIAL: Jan 27, 1927

20 UNDERTAKER: Edward Bryan — ADDRESS 1691 Orleans st

Spec.–7-17-26—A Co.—200 Bks.

Slick

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18367

## CERTIFICATE OF DEATH

× 60-001

E 18367

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. St Agnes Hospital St. 20-67 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Nettie Slick

(a) RESIDENCE NO. 2652 Lehman St. Ward W. Va

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | white | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Vernon Slick

6 DATE OF BIRTH (month, day, and year) May 2- 1900

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min.. |
|---|---|---|---|---|
| | 26 | 8 | 24 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER Louis Wilt

11 BIRTHPLACE OF FATHER (City or town) not Given

(State or country) W. Va

12 MAIDEN NAME OF MOTHER Emma Hankey

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country) "

14 Informant Husband - Vernon Slick

(Address) 2652 Lehman St.

Filed 2 7 1927 C. HAMPSON JONES, M. D. Registrar

Per R.F.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-26 1927

17 I HEREBY CERTIFY, That I attended deceased from 1-22, 1927, to 1-26, 1927,

that I last saw her alive on 1-26, 1927,

and that death occurred, on the data stated above, at 2 20 a m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

Sepsis ff f

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Goitre (over)

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Tests

(Signed) Theron Hunter, M. D.

1/26/1927 (Address) St. Agnes' Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount W. Va

Date of Burial Jan. 28 1927

20 UNDERTAKER George L. Schwab

ADDRESS 1401 Eutaw St.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18368
1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

37-001
E 18368
REGISTERED NO.

City of BALTIMORE: (No. 1017 Sharp St. 23-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lewis Williams

(a) RESIDENCE NO. 1017 Sharp St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | Col | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 10 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) School boy

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) N. C.

PARENTS

10 NAME OF FATHER Junius Williams

11 BIRTHPLACE OF FATHER (city or town)

(State or country) N. C.

12 MAIDEN NAME OF MOTHER Letter Coston

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) N. C.

14 Informant Junius Williams

(Address) 1017 Sharp St.

15 Filed ..... 19 .....

1-27-1927 Per ..... Registrar

HARRISON JONES, M. D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 Jan 24

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1927, to Jan 24, 1927, that I last saw h.. alive on Jan 23, 1927, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Acute Miliary Tuberculosis

(duration) ..... yrs. ..... mos. 21 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D T Carroll, M. D.

1/27/1927 (Address) 80 S. Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Mt Zion — Date of Burial Jan 27 1927

20 UNDERTAKER — R L Parham — ADDRESS 1216 E. Shaw St

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18369

## CERTIFICATE OF DEATH.

31 E 18369

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1619 Madison Ave ST. 14 WARD)

2-FULL NAME Annie Sheppard

(a) RESIDENCE NO. 1619 Madison Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (Write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Walter Sheppard

6 DATE OF BIRTH (month, day, and year) 1901

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs. or min. |
|---|---|---|---|---|
| | 26 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) South Boston Va (State or country)

PARENTS

10 NAME OF FATHER Fleetwood Boyd

11 BIRTHPLACE OF FATHER (city or town) Va (State or country)

12 MAIDEN NAME OF MOTHER Phyllis Crawford

13 BIRTHPLACE OF MOTHER (city or town) Va (State or country)

14 Informant Walter Sheppard

(Address) 1619 Madison Ave

15 Filed JAN 27 1927 Registrar

E. HAMPTON JONES, M. D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 15 1926 to Jan 27 1927

that I last saw her alive on Jan 23 1927

and that death occurred, on the date stated above, at 2.03 P.M.

The CAUSE OF DEATH* was as follows:

Pleurisy with Effusion (Tuberculous)

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Acute Carditis

Dilatation (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W Blassner, M. D.

1/26, 1927 (Address) 800 Mass Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL South Boston Va

DATE OF BURIAL Jan 29 1927

20 UNDERTAKER Samuel Hensley

ADDRESS 1618 Madison Ave

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18370 E 18370

## CERTIFICATE OF DEATH.

124

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 939 Pierce St. 15-26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harrison Carter

(a) RESIDENCE NO. 939 Pierce St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | Negro | Married |

5a If married, widowed or divorced HUSBAND of (or) WIFE of Mary Carter

6 DATE OF BIRTH (month, day, and year) unknown

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 55 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Norfolk Va

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Mary Carter

(Address) 939 Pierce St.

15 Filed 1927 Per C. HARRISON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 22, 1927, to Jan 24, 1927, that I last saw him alive on Jan 24, 1927, and that death occurred, on the date stated above, at 11-P m.

The CAUSE OF DEATH* was as follows:

Acc by accidental ingestion of Chemical Poisons

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chron. Nephritis

(duration) 1 yrs. 6 mos. 9 ds.

18 Where was disease contracted if not at place of death? Out of City & State

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Unconfirmed

(Signed) Wade H. Frost, M. D.

, 19 (Address) 613 W. Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL Jan. 28, 1927

20 UNDERTAKER Mrs. Katie R. Williams

ADDRESS 322 N. Schroeder St

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 18371
1-PLACE OF DEATH

90 E 18371
REGISTERED NO.

City of BALTIMORE: (No. 671- W mulberry St., 425 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha E. Parker

(a) RESIDENCE NO. 671-W mulberry St. Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | col | married |

5a If married, widowed, or divorced (or) WIFE of Samuel W. Parker

6 DATE OF BIRTH (month, day, and year) 8-12-1877

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 49 | 5 | 12 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic 10 01
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Deal's Island
(State or country) Md.

PARENTS

10 NAME OF FATHER John Whittington
11 BIRTHPLACE OF FATHER (city or town)
(State or country) md.
12 MAIDEN NAME OF MOTHER Charlotte Jones
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) md.

14 Informant Wm. Armstrong
(Address) Camp Parole, Md.

15 Filed JAN 27 1927, 19..... C. HAMPTON JONES, M. D.
By ..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-24 1927

17 I HEREBY CERTIFY, That I attended deceased from 1-22, 1927, to 1-24, 1927, that I last saw her alive on 1-22, 1927, and that death occurred, on the date stated above, at 4:10 p m.

The CAUSE OF DEATH* was as follows:
Chronic Valvular Heart disease
Hemiplegia

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. H. Jackson, M. D.
1-25 1927 (Address) 804 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Zion Cemetery — Date of Burial: Jan 28, 1927

20 UNDERTAKER: Mrs. Kate R. Williams — ADDRESS 322 N. Schroeder St.

Spec. 1—200 Bks.

E 18372

# HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 18372

## CERTIFICATE OF DEATH.

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH So Balto Gen'l Hosp.

City of BALTIMORE: (No. 1211 S Light St. 16-22 Ward)

2-FULL NAME John Frustaken Ford

(a) RESIDENCE NO. 604 N Appleton St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, ~~Married~~, ~~Widowed~~, ~~or Divorced~~. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6 DATE OF BIRTH (month, day, and year): Feb 24, 1852

7 AGE: Years 74 | Months 11 | Days 3 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer): 66

(c) Name of employer

9 BIRTHPLACE (city or town): Washington D C

(State or country)

PARENTS

10 NAME OF FATHER: Thos Gilbert Ford

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country): London England.

12 MAIDEN NAME OF MOTHER: Annie Trustum

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country): London England.

14 Informant: Mrs A Lummus Mcd.

(Address): 539 W. Fulton ave

15 Filed ..... 19 ..... C. HARRISON JONES, M. D. Registrar

NOV 27 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 26 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan 15, 1927, to Jan 26, 1927, that I last saw h.. alive on Jan 26, 1927, and that death occurred, on the date stated above, at 7:30 m.

The CAUSE OF DEATH* was as follows:

Oedema of Lungs

Myocarditis

(duration) ~~yrs~~ mos. ds.

CONTRIBUTORY (Secondary) _____

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? No Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) H G Miller, M. D.

, 19 (Address) S Bond Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London (Cat Run) Date of Burial 28 19 27

20 UNDERTAKER _____ ADDRESS _____

Spec.—1-12-23—M&T—500 Blks.

E 18373 HEALTH DEPARTMENT—CITY OF BALTIMORE E 18373

CERTIFICATE OF DEATH. + 159-003

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Humphreys 3rd

(a) RESIDENCE NO. 969 Sherman ave ST. Homer Col WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced. (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 26. 26.

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | | 5 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Col -
(State or country)

PARENTS

10 NAME OF FATHER Albert Humphreys

11 BIRTHPLACE OF FATHER (city or town) Col -
(State or country)

12 MAIDEN NAME OF MOTHER Ruth

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed 1927 19 HARRISON JONES, M.D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 21, 1927. to Jan 26, 1927

that I last saw h alive on Jan 26 1927

and that death occurred, on the date stated above, at 2.40 p. m.

The CAUSE OF DEATH* was as follows:

Epilepsy Congenital malformation Brain

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 1/26/27

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy & Clinical History

(Signed) George G. Finney, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Denver Col

DATE OF BURIAL Jan 27 19 27

20 UNDERTAKER John Stitzel

ADDRESS 1900 Eutaw Pl.

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18374

101-001

## CERTIFICATE OF DEATH.

E 18374

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 215 S Monroe St ST. 19-28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Elizabeth Castle

(a) RESIDENCE NO. 215 S Monroe St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 11 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced: HUSBAND of or) WIFE of Walter L Castle

6 DATE OF BIRTH (month, day, and year) Jany 31/1866

7 AGE: Years 60; Months 11; Days 24 25; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Elijah Shaw

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Elizabeth Stant

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant: Edgar E Baker

(Address) 1941 Ramsay St

Filed 1-27 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/25 1927

17 I HEREBY CERTIFY, That I attended deceased from 1/21 1927, to 1/25 1927, that I last saw h alive on 1/24 1927, and that death occurred, on the date stated above, at 12 05 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

CONTRIBUTORY (Secondary) Pulmonary Oedema (duration) yrs. mos 5 ds.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical only

(Signed) James R McDonough M. D.

1/26 1927 (Address) 1724 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Frederick Md.

DATE OF BURIAL: Jany 28 1927

20 UNDERTAKER: Harry N Armacost

ADDRESS: 4204 Ridgewood Ave

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18375

## CERTIFICATE OF DEATH.

74-001

22-36

E 18375

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. _____ St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Wheatley

(a) RESIDENCE NO. 547 Burgundy Alley St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Negro | ? |

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1872

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 55 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant

(Address) Records

Filed JAN 27 1927

HAMPSON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 25 1927

17

I HEREBY CERTIFY, That I attended deceased from August 20, 1925, to January 25, 1927, that I last saw him alive on January 24, 1927, and that death occurred, on the date stated above, at 9 05 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Sclerosis

Hypertension

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? general appearance

(Signed) Grayson Smith, M. D.

Jan 25, 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

1927

20 UNDERTAKER ADDRESS

JAN 27 1927

Commissioner of Health

Spec.—1-10-21—M&T—1500 Bks.

E 18376

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18376

## CERTIFICATE OF DEATH.

100

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 66 S Carrollton ave ST. 18-29 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bridget A Grady

(a) RESIDENCE No. 68 S Carrollton Ave ST., 18 WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jas Grady

6 DATE OF BIRTH (month, day, and year) July 4 1874

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 52 | 6 | 21 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Patrick Kelley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Helen Carroll

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Margaret Fenton

(Address) 68 S Carrollton ave

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

By .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/25/27 19

17 I HEREBY CERTIFY, That I attended deceased from 1/20/27 . 19 . to 1/25/27 . 19 .

that I last saw h alive on 1/25/27 19 ,

and that death occurred, on the date stated above, at 11 ½ p. m.

The CAUSE OF DEATH* was as follows:

Cardiac failure

(duration) yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) T. H. Wessler, M. D.

(Address) 25 S Mt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL Jan 29 1927

20 UNDERTAKER John J Fields

ADDRESS 1200 W Lombard

Spec.—12-9-25—A Co.—200 Bks.

Winfield

HEALTH DEPARTMENT—CITY OF BALTIMORE 90 Bowdoin

E 18377

# CERTIFICATE OF DEATH.

REGISTERED NO. E 18377

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospitals 9-46 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Winfield

(a) RESIDENCE NO. 2714 Reese St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1892

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 35 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Driver Roadscraper

(b) General nature of industry, business, or establishment in which employed (or employer): 03

(c) Name of employer: Va

9 BIRTHPLACE (city or town): Va

(State or country)

PARENTS

10 NAME OF FATHER: Grant Winfield

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Va

12 MAIDEN NAME OF MOTHER: Jones

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Va

14 Informant: Grant Winfield

(Address) 2714 Reese st.

JAN 27 1927 FILED HARRISON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927

Jan 23,

17

I HEREBY CERTIFY, That I attended deceased from March 22, 1926, to Jan. 23, 1927, that I last saw him alive on Jan 23 1927 and that death occurred, on the date stated above, at 5-30 p.m.

The CAUSE OF DEATH* was as follows: Osteomyelitis of Right Femur with Acute Exacerbations Chronic Nephritis

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical & Laboratory

(Signed) W. Bruce Mitchell, M. D.

, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Laurel Cemetery | 1/27/27 |

20 UNDERTAKER: Mrs. R. G. Elliott

ADDRESS 1725 Ashland ave

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18378

## CERTIFICATE OF DEATH.

90 ✓ E 18378

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 906 China St. St. 14-20 Ward)

2-FULL NAME James T. Delahay.(C)

(a) RESIDENCE NO. 1734 McCulloh St. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 11 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male. | Colored | Married. |

3a If married, widowed or divorced HUSBAND of (XXXXXXXX) Eva Delahay.(C)

6 DATE OF BIRTH (month, day, and year) January 31, 1870

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 56 | 11 | 28 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook.

(b) General nature of industry, business, or establishment in which employed (or employer) B. & O. R. R. Co.

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER James T. Delahay.(C)

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Do not know.

14 Informant Eva Delahay.(C) wife.

(Address) 1734 McCulloh St.

15 Filed JAN 27 1927 HAMPSON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 23, 1927. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

_____ (duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) _____ (duration) ____ yrs. ____ mos. ____ ds.

(Signed) Otto R. Reinhardt M. D.
(Coroner)

1/26 19 27 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?_____

Former or usual residence_____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery Date of Burial 1/28/27

20 UNDERTAKER Jno. Geo. A. Holland ADDRESS 16 31 Druid Hill Ave

Spec.—1-12-23—M&T—500 Bks.

E 18379

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 ✓

REGISTERED NO. E 18379

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1119 Aisquith ST., 1014 WARD)

2-FULL NAME Thomas W. Bomberger

(a) RESIDENCE NO. 1119 Aisquith ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widower |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Eva Bomberger

6 DATE OF BIRTH (month, day, and year) July 20-1862

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs or ... min |
|---|---|---|---|---|
| | 64 | 6 | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Can Capper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

0816

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Robt. H. Bomberger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Frances Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Jennie Schaper
(Address) 1119 Aisquith St.

15 Filed JAN 27 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 25. 1927. to Jan. 26. 1927.

that I last saw him alive on Jan. 26. 1927

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of none

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. Lee Wagner M. D.

1/27. 1927 (Address) 1206 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Baltimore Cemetery | Jan 29 1927 |
| 20 UNDERTAKER Zirkler & Zirkler | ADDRESS 1739 E Eager St. |

Cor.—12-9-25—A Co.—200 Bks. Alexander Krawczykowski

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18380 — CERTIFICATE OF DEATH. — 1803 E 18380

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St. No 36 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME A. Krawczykowski

(a) RESIDENCE 2021 Lane Edgewood St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male — 4 Color or Race: White — 5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1882

7 AGE: Years 45 — Months — Days — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Helper

(b) General nature of industry, business, or establishment in which employed (or employer): Ry

(c) Name of employer: —

9 BIRTHPLACE (city or town)

(State or country) Poland

PARENTS

10 NAME OF FATHER Antoni Krawczykowski

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Antczyn

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Bronislaw Krawczykowski

(Address) 2021 Lane Edgewood St.

15 Filed JAN 7 1927 — C. HARRISON JONES, M. D. Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death the day stated above.

The CAUSE OF DEATH* was as follows: Multiple Fractures Auto Acc

(Duration) yrs. mos. 1 hr

CONTRIBUTORY (Secondary) Shock

(Duration) yrs. mos. ds.

(Signed) H. C. Blades M. D.

(Coroner)

17 (Address) 143 N Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary — Date of Burial Jan 28 1927

20 UNDERTAKER H. W. Gazewski — ADDRESS 1930 Eastern Ave

Urlahs.

Spec.-7-17-26—A Co.—200 Bks.

E 18381

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

4th E 18381

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 920 S. Curley St. St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Madeline Urlahs.

(a) RESIDENCE NO. 920 S. Curley St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S. if of foreign birth? 40 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Herman Urlahs.

6 DATE OF BIRTH (month, day, and year): July 21-1869

7 AGE: Years 57 Months 6 Days 6 IF LESS than 1 day ____ hrs. or ____ min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER: John Wolf.

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Margaret Schmid

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Mrs. Schauer (Sister)

(Address): S. Bouldin St.

15 Filed 2 7 1927 19 C. HARRISON JONES M. D. Registrar

Per K.L.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 25 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1926, to Jan 25, 1927,

that I last saw her alive on Jan 25, 1927,

and that death occurred, on the data stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Primal Carcinomatosis

(Cervix)

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary): Ex haustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? about 4 yrs

Did an operation precede death? Date of Nov 10 1926 St agnes Hospital

Was there an autopsy? no

What test confirmed diagnosis? Pathology Laboratory

(Signed) John L. Oliver M. D.

(Address) 19 Jan 27. 1927 35 N. Potomac St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cem. Date of Burial: Jan. 28th 1927

20 UNDERTAKER: Lilly & Julius

ADDRESS: Wolfe

Key important items. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

90 E 18382

REGISTERED NO.

E 18382
1-PLACE OF DEATH

City of BALTIMORE: (No. 1421 W. Lanvale St. 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jane Keller

(a) RESIDENCE NO. 1421 W. Lanvale St. Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: ~~Male~~ Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Samuel E. Keller

6 DATE OF BIRTH (month, day, and year): Mar. 16, 1851

| 7 AGE | Years | Months | Days | IF LESS than 1 day ...hrs. or ...min.. |
|---|---|---|---|---|
| | 75 | 10 | 9 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Funkstown
(State or country): Md.

PARENTS

10 NAME OF FATHER: Henry Stonebreaker

11 BIRTHPLACE OF FATHER (City or town):
(State or country): Md.

12 MAIDEN NAME OF MOTHER: Angelica E. Reutch

13 BIRTHPLACE OF MOTHER (city or town):
(State or country): Md.

14 Informant: Mrs. Harry Keller
(Address) 18 Broadway - Hagerstown

15 Filed JAN 27 1927 19 Harrison Jones M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 25 19 27

17 I HEREBY CERTIFY, That I attended deceased from Jan 4, 1927, to Jan 25, 1927, that I last saw h.. alive on Jan 24, 1927, and that death occurred, on the date stated above, at 10.10 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary): Pulmonary tuberculosis

(duration) 1 yrs. — mos. — ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) M Bruce Rowland, M. D.

(Address) 626 N. Gilmor St.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| London Park Cem. | Jan. 27 1927 |
| 20 UNDERTAKER | ADDRESS |
| Wm. J. Pickerel Sons | Mt. Royal Ave |

Very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18383

E 18383

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Joseph's Hosp. 8-16

CITY OF BALTIMORE: (No. ..... ST., ..... WARD)

REGISTERED NO. 100 1001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roger L Smith

(a) RESIDENCE NO. 2622 E Preston ST., ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 29 1921

7 AGE — Years: 5 — Months: 3 — Days: 25 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Sidney Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): City

12 MAIDEN NAME OF MOTHER: Thelma Ford

13 BIRTHPLACE OF MOTHER (city or town) (State or country): City

14 Informant: Mrs Smith

(Address) 2622 E Preston St

15 7 1927 C. HAMPSON JONES, M. D. Registrar

By .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/24 1927

17 I HEREBY CERTIFY, That I attended deceased from 1/20, 1927, to 1/24, 1927, that I last saw him alive on 1/24, 1927, and that death occurred, on the date stated above, at 11 45 m.

The CAUSE OF DEATH* was as follows:

Cellulitis Neck

Streptococcic Septicemia

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 1/21/27

Was there an autopsy? no

What test confirmed diagnosis? Laboratory

(Signed) F. L. McAnally, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem

DATE OF BURIAL: 1/28/1927

20 UNDERTAKER: J. J. Moran

ADDRESS 300 E. Balto St.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18384

## CERTIFICATE OF DEATH.

100-001

REGISTERED NO. E 18384

1-PLACE OF DEATH St Josephs Hospital

CITY OF BALTIMORE: (No. Caroline & Aliceri. ST. N/A WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Zieglar

(a) RESIDENCE NO. 1732 E. Pratt ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female. 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Charles J. Zeigler.

6 DATE OF BIRTH (month, day, and year) July 25. 1857

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 72 | 6 | 1 3 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Robt. Ward.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Marg. Albrook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Mr. H. J. Zeigler. (Address) 502 E. 20th St.

15 Filed JAN 1927 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 24, 1927, to Jan 26, 1927, that I last saw her alive on Jan 26, 1927, and that death occurred, on the date stated above, at 12:45 p. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia.

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? — Date of —

Was there an autopsy? None. What test confirmed diagnosis? Clinical.

(Signed) Clement R. Momac, M. D.

, 19 (Address) St Josephs Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park. Cem.

DATE OF BURIAL 1/28 1927

20 UNDERTAKER M. M. Wiedefeld.

ADDRESS 501 E. 22 St.

Spec.—12-9-25—A Co.—200 Blks.

# E 18385

## HEALTH DEPARTMENT—CITY OF BALTIMORE

### CERTIFICATE OF DEATH.

101-001

# E 18385

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 45 S. Schroeder St. 18-29 Ward)

2-FULL NAME Michael Burke

(a) RESIDENCE NO. 45 S. Schroeder St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Widowed |

3a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Margaret Burke

6 DATE OF BIRTH (month, day, and year) Jan 6. 1860

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 67 | ' | 19 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) R.R. Laborer

(c) Name of employer B & O. R. R.

9 BIRTHPLACE (city or town)

(State or country) Ireland

PARENTS

10 NAME OF FATHER Richard Burke

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Murphy

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant James F. Burke

(Address) 45 S. Schroeder St.

15 Filed C. HAMPSON JONES M. D.

JAN 27 1927 Per Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 20 1927, to Jan 25, 1927, that I last saw him alive on Jan 25, 1927, and that death occurred, on the date stated above, at 7.7. P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Arterio sclerosis & Myocarditis

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Clinical Tests

What test confirmed diagnosis?

(Signed) Nancy E Ohla, M. D.

Jan 26 1927 (Address) 1203 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR REMOVAL New Cathedral Cem. Date of Burial Jan 29 1927

20 UNDERTAKER Logan & Son ADDRESS Chas F. J. Logan 90 Hollins St

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18386

90 E 18386

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Joseph's Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Caroline & Oliver ST. 9-46 WARD)

2-FULL NAME David. Edmund. Walsh

(a) RESIDENCE NO. 826 E 29th ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. [illegible] mos. [illegible] ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | white | Married. |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Virginia Walsh.

6 DATE OF BIRTH (month, day, and year) 1874

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 53 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Michael Walsh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Mary Houck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Michael E. Walsh. (Address) West minster Md.

15 Filed 7 1927 Co HAMPSON JONES, M. D. Registrar. Per Asst

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 26 1927 to Jan. 27 1927, that I last saw him alive on Jan. 27 1927, and that death occurred, on the date stated above, at 12: 3p m.

The CAUSE OF DEATH* was as follows:

Hypertension.
Cardio-Renal.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) A. L. McAnally, M. D.

, 19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westminster St Johns — DATE OF BURIAL 1/30 1927

20 UNDERTAKER H. Bankard & Son — ADDRESS Westminster

Spec.—1-12-23—M&T—500 Bks.

E 18387

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18387

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Wetherdville Rd (St.) Hillsdale (Ward) 25

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ann E Moran

(a) RESIDENCE No. Wetherdville Rd. ST. Hillsdale WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Stephen Moran

6 DATE OF BIRTH (month, day, and year): Oct 23 1864

7 AGE — Years: 62 Months: 3 Days: 12 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Thomas Cadwgon

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Camille

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Stephen Moran Hillsdale Md

15 Filed 7 1927, 19 — C. HAMPSON JONES, M. D. Registrar. Per RRH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 25 1927

17 I HEREBY CERTIFY, That I attended deceased from June, 1924, to Jan 25, 1927, that I last saw h alive on Jan 24, 1927, and that death occurred, on the date stated above, at 7:30 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) A. C. Lynch, M. D.

(Address) 4509 Liberty Hgts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem — DATE OF BURIAL: 1/28/27

20 UNDERTAKER: Tenge & Shirley — ADDRESS: Fulton Ave

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18388

# CERTIFICATE OF DEATH

90 E 18388

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 2330 Barclay St. 17-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Hess

(a) RESIDENCE NO. 2330 Barclay St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary E. Hess

6 DATE OF BIRTH (month, day, and year): Feb. 15-1854

7 AGE — Years: 72 Months: 11 Days: 11 IF LESS than 1 day ... hrs. or ... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Engineer

(b) General nature of industry, business, or establishment in whirh employed (or employer): Retired 13

(c) Name of employer: Penna R R Co

9 BIRTHPLACE (city or town) (State or country): Pennsylvania

PARENTS

10 NAME OF FATHER: Henry Hess

11 BIRTHPLACE OF FATHER (City or town) (State or country): Pennsylvania

12 MAIDEN NAME OF MOTHER: ? Messersmith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pennsylvania

14 Informant (Address): Mary C. Hess 2330 Barclay St.

15 Filed 1927 C. HARRISON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): January 26th 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 19th 1927 to Jan 26th 1927

that I last saw h— alive on Jan 26th 1927

and that death occurred, on the date stated above, at 1020 a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Myocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Cerebral Anemia

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Geo. W. Hyslop M.D. M. D.

1/26 1927 (Address) 401 E. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — Date of Burial: 1/28 1927

20 UNDERTAKER: William Cook — ADDRESS: 502 E Balt

Spec—12-23-21—E.B.R.S.—400 Bks.

E 18389

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18389

## CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

City of BALTIMORE: (No. 2635 Greenmount St., 9-50 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard A. Chenowerth

(a) Residence No. 2635 Greenmount St., ..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 2-26-1886

7-AGE, 45 yrs. 11 mos. ..... ds. If LESS than 1 day, .... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) Self 050

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Wm J Chenowerth

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Elizabeth P. Castay

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Wm J. Chenowerth

(Address) 2635 Gt. Mts

15- Filed 1927 C. HAMPSON JONES, M. D. Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) January 26 27

17- I HEREBY CERTIFY, That I attended deceased from Jan 19 27 to Jan 26 27,

that I last saw h.. alive on Jan 26 27

and that death occurred, on the date stated above, at 1.55 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) —

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Geo W Humpstone M. D.

1/26/ 1927 (Address) 401 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19-PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL. |
|---|---|
| Loudon Park Cem | Jan 29 27 |
| 20-UNDERTAKER. Wm Cook | ADDRESS 502 E 16th. |

Spec.–1-10-21 M&T 1500 Bks.

E 18390

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 18390

1-PLACE OF DEATH Balto City Hospls. 16-37 100-001

CITY OF BALTIMORE: (No. Balto Md. ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Herr.

(a) RESIDENCE NO. Unknown ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1866

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs or ..... min. |
|---|---|---|---|---|
| | 60 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work /

(b) General nature of industry, business, or establishment in which employed (or employer) Housework 027

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Balto City Hospitals (Address) Balto Md

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-24 1927

17 I HEREBY CERTIFY, That I attended deceased from 10-22 1926 to 1-24- 1927

that I last saw her alive on 1-24 1927

and that death occurred, on the date stated above, at 9.15 P. m.

The CAUSE OF DEATH* was as follows:

Terminal Bronchopneumonia

(duration) yrs mos ds.

CONTRIBUTORY (Secondary) Senile Psychosis w/ Deterioration.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Harry Greenwald M. D.

1/25/1927 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL June 1927

20 UNDERTAKER William Cook 902 E Fayette ADDRESS

Spec.—1-19-21—M&T—1500 Bks.

E 18391 HEALTH DEPARTMENT—CITY OF BALTIMORE 1401 ✓

14 E 18391

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2343 Eastern av. ST., 1 1/3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Gohr

(a) RESIDENCE NO. 2343 Eastern av. ST., 1 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? 46 yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Johanna Gohr

6 DATE OF BIRTH (month, day, and year): Aug 24 1842

7 AGE: Years 82 Months 6 5 Days 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Louis Gohr

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Edith Boehm (Address) 2343 Eastern av.

15 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): January 26 1927

17

I HEREBY CERTIFY, That I attended deceased from January 15, 1927, to January 26, 1927.

that I last saw him alive on January 25, 1927.

and that death occurred, on the date stated above, at 9 15 a/p m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Caleb R Bothey M. D.

Jan 29 1927 (Address) 100 S Patterson Park ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mathews Cem. DATE OF BURIAL: Jan 29 1927

20 UNDERTAKER: Louis Heemann ADDRESS: 32 & Broadway

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18392

## CERTIFICATE OF DEATH.

11-001 ✓ E 18392

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 1127 William St. 24-33 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles F. Bradford.

(a) RESIDENCE NO. 1127 William St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. 18. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 Color or Race: White,

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: infant.

6 DATE OF BIRTH (month, day, and year): April, 9, 1926.

7 AGE — Years: | Months: 9, | Days: 18. | IF LESS than 1 day.....hrs. or.....min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER: Preston B. Bradford

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER: Margaret Elliott.

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Balto. Md.

14 Informant: Preston B. Bradford, (Father)

(Address) 1127 William Street.

JAN 27 1927 C. HAMPSON JONES, M. D.

Registrar

Per _____

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 Jan 27/27

17 I HEREBY CERTIFY, That I attended deceased from Jan 24/27 19..., to Jan 27/27 19..., that I last saw h... alive on Jan 27/27 19..., and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ...yrs. ...mos. 4 ...ds.

CONTRIBUTORY (Secondary) [illegible]

(duration) ...yrs. ...mos. 1 ...ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? [illegible] Date of —

Was there an autopsy? [illegible]

What test confirmed diagnosis? [illegible]

[illegible], M. D.

(Address) 1 W Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem Date of Burial: Jan 29, 1927

20 UNDERTAKER: A. Howard Eakins ADDRESS: 38 E Fort Ave

Spec.—1-12-23—M&T—500 Bks.

E 18393 HEALTH DEPARTMENT—CITY OF BALTIMORE E 18393

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 125 W. Randall ST. 23-32 WARD)

REGISTERED NO. 1000

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theresa M. Stubbins

(a) RESIDENCE NO. 125 W. Randall ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | white | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George A. Stubbins

6 DATE OF BIRTH (month, day, and year) May 27-1859

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs or ... min. |
|---|---|---|---|---|
| | 67 | 7 | 29 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER George Riger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Jena Henning

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Stubbins (Address) 125 W Randall St.

1827 C. HAMPSON JONES, M. D. Registrar

Per

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, that I attended deceased from Jan 22, 1927, to Jan 26, 1927

that I last saw h[illegible]ive on Jan 26, 1927

and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. E. Campbell M. D.

(Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Mt. Olivet Cemetery | Jan 29 1927 |
| 20 UNDERTAKER | ADDRESS |
| J. A. Krause & Son | 703 Hanover St |

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18394 E 18394

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Josephs Hospital

CITY OF BALTIMORE; (No.) Caroline & Oliver. ST. 15-66 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Philip Sheridan Warnick

(a) RESIDENCE NO. 2137 Mount Holy ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male. | white. | Single. |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 25 1867

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 59 | 4 | 2 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Richard J. Warnick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Melvina McKean

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Mrs. Elwood Henderson
(Address) 237 Yale Ave.

15 Jan 7 1927 C. HAMPSON JONES, M. D.
19 Per ____ Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 17 1927, to Jan. 27 1927.
That I last saw him alive on Jan. 27 1927,
and that death occurred, on the date stated above, at 5:20 A. m.

The CAUSE OF DEATH* was as follows:
Cancer of stomach.
2nd ary Cancer of liver —
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac dilatation
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home.
Did an operation precede death? No - Date of ____
Was there an autopsy? yes.
What test confirmed diagnosis? Clinical & Autopsy
(Signed) Clement K. Monrad, M. D.
Jan 27 1927 (Address) St Joseph's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Baltimore Cemetery | Jan. 29 1927 |

20 UNDERTAKER for J. B. Cook
ADDRESS 1003 W. Balto St

Spec.—1-10-21—M&T—1500 Bks.

(Bourne)

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18395

E 18395

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Sq Hospital (STREET) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas H. Bourne

(a) RESIDENCE NO. 627 Red Wood St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1864

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 63 | -- | -- | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shipping Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): Bragers

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Prince Georges Co., Md.

PARENTS

10 NAME OF FATHER John Bourne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Hodgkin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Blake Bourne
(Address) 735 W. North Ave.

15 Filed Jan 26 1927 C. HAMPSON JONES, M. D. Registrar
Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/26/27

17 I HEREBY CERTIFY, That I attended deceased from 1/26/27, 19, to 1/26/27, 19,
that I last saw him alive on 1/26/27, 19,
and that death occurred, on the date stated above, at 11 p. m.
The CAUSE OF DEATH* was as follows:

Carcinoma of jaw 4 wks (duration) yrs. mos ds.
CONTRIBUTORY (Secondary) Pyrexial Failure. (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Franklin Hospital
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) C. Hampson Jones, M. D.
Jan. 26 19 27 (Address) Franklin Sq Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Jan. 28 19 27

20 UNDERTAKER: Joseph F. Cook — ADDRESS: 1003 W. Baltimore

Spec.—1-12-23—M&T—500 Bks.

E 18396

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18396

## CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2016 Etting St. 14th Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Robinson

(a) RESIDENCE NO. 2016 Etting ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) January 16, 1927

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 0 | 0 | 10 11 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Maryland (State or country)

PARENTS

10 NAME OF FATHER Romie Landon Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lancaster County Virginia

12 MAIDEN NAME OF MOTHER Hattie Mary Logan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lancaster County, Virginia

14 Informant Robert Robinson

(Address) 2016 Etting St.

15 Filed 1927, 19 C. HAMPSON JONES, M. D. Registrar

Per OKS

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 26 1927

17 I HEREBY CERTIFY, That I attended deceased from January 16, 1927, to January 26, 1927, that I last saw him alive on January 26, 1927 and that death occurred, on the date stated above, at 2 00 p m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Syphilis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Congenital

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M. Alexander Morey M. D.

, 19 (Address) 1516 Madeira Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 1/28/1927

20 UNDERTAKER Mrs. Geo. E. Holland

ADDRESS 1601 Druid Hill

Spec.-7-17-26—A Co.—200 Bks.

E 18397

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 18397

REGISTERED NO. 129

1-PLACE OF DEATH

City of BALTIMORE: (No. 2919 Windsor Ave St. 15-61 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert B Joyce

(a) RESIDENCE NO. 2919 Windsor Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth Joyce

6 DATE OF BIRTH (month, day, and year): Jan 28, 1850

7 AGE — Years: 76 Months: 11 Days: 27 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country): Md

PARENTS

10 NAME OF FATHER: John Joyce

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Balto Md

14 Informant: Elizabeth Joyce

(Address): 2919 Windsor Ave

15 Filed JAN 28 1927 19

C. HAMPSON JONES, M. D.

Per Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 25 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1923, to Jan 25 1927

that I last saw h alive on Jan 25 1927

and that death occurred, on the date stated above, at 9:15 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 4 yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Sub.

(Signed) H. E. Hoen, M. D.

1-26. 1927 (Address) 5600 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

Date of Burial: Jan 28 1927

20 UNDERTAKER: J. H. Cook

ADDRESS: 503 Eutaw St

Very Important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

Harding

E 18398

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 18398

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospital 26-37 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Rhodes.

(a) RESIDENCE NO. Balto City Hosp St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Wid

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1860

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 67 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Maid

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town): —

(State or country) —

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town):

(State or country)

14 Informant: Records

(Address): Baltimore City Hall

Filed JAN 28 1927 C. HARRY JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 Jan 25, 1927

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1924 to Jan 25, 1927

that I last saw h alive on Jan 25, 1927

and that death occurred, on the date stated above, at 10 pm

The CAUSE OF DEATH* was as follows: Chronic Myocarditis

Senility

(duration) Unknown

CONTRIBUTORY (Secondary) Senile Bronchitis

(duration) yrs. mos. 2 ds.

Is Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. D.

, 19 (Address) Balto City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — Date of Burial: Jan 29 1927

20 UNDERTAKER: E. Rhodes — ADDRESS: 504 Aisquith St

Spec.—1-12-23—M&T—500 Blks.

E 18399

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

11-001

E 18399

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1462 Woodall ST. 24 33 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Meekins

(a) RESIDENCE NO. 1462 Woodall ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. 4 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male. | white | Widower |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Sept 11-1858

| 7 AGE | Years | Months | Days | If LESS than 1 day... hrs or min |
|---|---|---|---|---|
| | 68 | 4 | 14 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant J. Wesley Meekins (Address) 1462 Woodall.

15 Filed JAN 28 1927 19 C. HARRISON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-25 1927

17

I HEREBY CERTIFY, That I attended deceased from 1-18, 1927, to 1-25, 1927,

that I last saw h[illegible] alive on 1-25, 1927

and that death occurred, on the date stated above, at 9-30 P m.

The CAUSE OF DEATH* was as follows:

Grippe

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 3. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) L. E. Luyeck, M. D.

1/26, 1927 (Address) 910 Leglet St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Forsley Co Hereford Md. | 1/28 1927 |
| **20 UNDERTAKER** | **ADDRESS** |
| J. Frew McCauley | 130 E. [illegible] |

Spec.—1-12-23—M&T—500 Blks.

E 18400

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 18400

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1805 E. Fayette St. (Ward) 10-21

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Solomon

(a) RESIDENCE NO. 1805 E. Fayette St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? 17 yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| F | W | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min |
|---|---|---|---|---|
| | 68 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1439 Eutaw St

Filed Jan 28 1927 Harry Jones, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 28 1927

17 I HEREBY CERTIFY, That I attended deceased from June, 1926, to Jan. 27, 1927, that I last saw h alive on Jan. 27, 1927 and that death occurred, on the date stated above, at 8 a m

The CAUSE OF DEATH* was as follows:

Uremia
Sclerosis
hypertension
chronic interstitial nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 2.

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical.

(Signed) R. A. Nicholson, M. D.

Jan. 28 1927 (Address) 2230 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt Carmel

DATE OF BURIAL Jan 30 1927

20 UNDERTAKER Jack Lewis

ADDRESS 1439 Eutaw

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18401

101-001

## CERTIFICATE OF DEATH.

E 18401

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 32 N. Spring St 6-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rebecca Butler

(a) RESIDENCE NO. 32 N. Spring St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8y yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| female | col | widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year)

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 52 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of Industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Henry Smith

(Address) 32 N. Spring St

Filed 1927 CHARLES JONES, M. D.

Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25-27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Pneumonia (Lobar)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Collins M. D.

(Coroner)

1/27/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ....mos., ....ds. In the State ....yrs., ....mos., ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Date of Burial: Jan 28 1927

20 UNDERTAKER: John W. Henderson ADDRESS: 1502 E Monument St

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18402

## CERTIFICATE OF DEATH.

10 E 18402

8-17

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1621 N. Broadway ST. WARD)

2-FULL NAME Ira W. Fonshill

(a) RESIDENCE NO. 1621 N. Broadway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha Schaum Fonshill

6 DATE OF BIRTH (month, day, and year) Aug. 15, 1866

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 60 | 5 | 10 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Travelling

(b) General nature of industry, business, or establishment in which employed (or employer) Salesman

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Boydton, Va.

PARENTS

10 NAME OF FATHER Wm. H. Fonshill

11 BIRTHPLACE OF FATHER (city or town) Hanover (State or country) Pa.

12 MAIDEN NAME OF MOTHER Minerva Drusneight

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mrs. Bertha S. Fonshill

(Address) 1621 N. Broadway

15 Filed JAN 28 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 25, 1927

17 I HEREBY CERTIFY, That I attended deceased from ~~dec~~ Jan 1 1927 to ~~dec~~ , 19 .

that I last saw him alive on Jan 25 , 1927

and that death occurred, on the date stated above, at 4.55 p. m.

The CAUSE OF DEATH* was as follows:

Chr Pleurisy

Contributory Pulmon. Edema 1 wk

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Dont know

Did an operation precede death? 6 mos Tapchost

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W S. Rey , M. D.

Jan 28 , 1927 (Address) 1639 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Jan 28 1927

20 UNDERTAKER John F. Denny

ADDRESS 715 Light St

Spec.—12-9-25—A Co.—200 Bks.

Sugar.

# E 18403

## HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

### CERTIFICATE OF DEATH.

E 18403

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 3-5 Ward)

2-FULL NAME Herman Sugar

(a) RESIDENCE NO. 1139 E Balto St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 7 mos. 25 ds. How long in U. S., if of foreign birth? yrs. 7 mos. 25 ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| M. | W | S. |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 3/20

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | — | 7 | 25 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER Friedel Sugar

11 BIRTHPLACE OF FATHER (city or town) Russia

(State or country)

12 MAIDEN NAME OF MOTHER Rebecca Silverman

13 BIRTHPLACE OF MOTHER (city or town) Russia

(State or country)

14 Informant Friedel Sugar

(Address) 1139 E Balto St

Filed JAN 28 1927, 19..... C. HARRISON JONES, M. D.

Registrar

For

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Jan 27, 1922, to Jan 26, 1927

that I last saw h..... alive on Jan 26, 1927

and that death occurred, on the date stated above, at 3 4 m.

The CAUSE OF DEATH* was as follows:

Pneumonia (?)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY

(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) Max H. Rawlefs M. D.

1/27, 19 27 (Address) Sinai Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt Carmel Rd Date of Burial 1/28 19 27

20 UNDERTAKER Jos Lunson & Bro ADDRESS 1127 E Balto St

Spec.—12-9-25—A Co.—200 Bks.

E 18404

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

101-001

E 18404

REGISTERED NO. 5

1-PLACE OF DEATH

City of BALTIMORE: (No. 6-9 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pleasant Bird

(a) RESIDENCE NO. 138 N. Bond St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Negro | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1901

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 26 | | | |

8 OCCUPATION OF DEACESED

(a) Trade, profession or particular kind of work Laborer D

(b) General nature of industry, business, or establishment in which employed (or employer) 04

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER Pleasant Bird

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Kate —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant

(Address) Records

Filed JAN 28 1927 HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 26 1927

17

I HEREBY CERTIFY, That I attended deceased from January 25, 1927, to January 26, 1927, that I last saw him alive on January 26, 1927, and that death occurred, on the date stated above, at 12 30 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? N.D. Date of

Was there an autopsy? no

What test confirmed diagnosis? general & laboratory

(Signed) A. Hoopes Smith, M. D.

Jan 28 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Smith Field Va Date of Burial Jan 28 1927

20 UNDERTAKER Hamm Easton ADDRESS 916 E. Pratt St.

Very important. See instructions on back of certificate.

E 18405

# HEALTH DEPARTMENT--CITY OF BALTIMORE

## CERTIFICATE OF DEATH

11 E 18405

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 203 E. Preston ST. 11-15 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Robert Belanbe Abell

(Residence in Baltimore: No. 203 E. Preston St.: 51 yrs. mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word) |
|---|---|---|
| Male | White | Married |

6 DATE OF BIRTH July (Month) 30 (Day), 1876 (Year)

7 AGE 50 yrs. 5 mos. 27 26 ds. If LESS than 1 day, ..... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Clerk 09
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) St Marys Co Md

PARENTS

10 NAME OF FATHER Robert Abell

11 BIRTHPLACE OF FATHER (State or country) St Marys Co Md

12 MAIDEN NAME OF MOTHER Serena Harden

13 BIRTHPLACE OF MOTHER (State or country) St Marys Co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Helen Abell

(Address) 203 E. Preston St

15 Filed JAN 28 1927 C. HAMPSON JONES, M. D. REGISTRAR

By HH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan (Month) 26 (Day), 1927 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 15, 1927. to. Jan. 26 1927 that I saw him alive on Jan. 26, 1927. and that death occurred, on the date stated above, at 11:30 A. m.

The CAUSE OF DEATH* was as follows:

Apoplexy duration

(Duration) ..... yrs. ..... mos. 4 or 5 ds

Contributory (SECONDARY) Emphysema

(Duration) ..... yrs. ..... mos. 11 ds.

(Signed) Henry M. Bayless M. D.

Jan. 26, 1927 (Address) 2805 N. Calvert St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL New Cathedral

DATE OF BURIAL Jan 29 1927

20 UNDERTAKER George J. Smith

ADDRESS 1531 Hollins St

IS VERY IMPORTANT. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18406

## CERTIFICATE OF DEATH

74-002

E 18406

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. University Hospital St. 4-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard Peters Doll

(a) RESIDENCE NO. Owings Mills Md St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. — mos. 9 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widower |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harriet L Doll

6 DATE OF BIRTH (month, day, and year) Jan 1 1856

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 71 | | 27 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltv Md

(State or country)

PARENTS

10 NAME OF FATHER Daniel Doll

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Baltv Md

12 MAIDEN NAME OF MOTHER Mary Peters

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltv Md

14 Informant Lula B Doll

(Address) Owings Mills Baltimore Md

15 Filed JAN 28 1927 C. HAROLD JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 28 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 19, 1927, to Jan 28, 1927, that I last saw him alive on Jan 28, 1927, and that death occurred, on the date stated above, at 1:40 A m.

The CAUSE OF DEATH* was as follows:

Cerebral embolism following suprapubic cystotomy

(duration) Few minutes yrs. mos. ds.

CONTRIBUTORY (Secondary) Marked generalized sclerosis (duration) several years yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of 1/27/27

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M Hurwitz, M. D.

, 19 (Address) University Hospital Baltimore

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Loudon Park | Jan 27 1927 |
| 20 UNDERTAKER George J. Smith | ADDRESS 1532 Hollins |

Very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

Ida Alexander ✓

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18407

## CERTIFICATE OF DEATH.

90 E 18407

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home Infirmary, 6-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida alexander

(a) RESIDENCE NO. Church Home Infirmary Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 1st 1847

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 79 | 6 | 22 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town)

(State or country) Balto Md

PARENTS

10 NAME OF FATHER James Alexander

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto Md

12 MAIDEN NAME OF MOTHER Frances Elwood

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto Md

14 Informant Lillian Elliott

(Address) 2306 Eleanor Ave Balto

Filed JAN 28 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 26 1927 19

17 I HEREBY CERTIFY, That I attended deceased from 1-21-27, 19..., to 1-26-27, 19..., that I last saw h.. alive on Jan 26, 1927, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows: Myocardial Failure Acute -

(duration) ...yrs. ...mos. 5 ds.

CONTRIBUTORY (Secondary) Myocarditis, arteio - Sclerosis, Senile Dementia (duration) Many yrs. — mos. — ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No -

What test confirmed diagnosis?

(Signed) Merrywell I. Shelton, M. D.

, 19 (Address) Church Home Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — Date of Burial: Jan 27 1927

20 UNDERTAKER: George J. Smith — ADDRESS 1532 Hollins

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18408

## CERTIFICATE OF DEATH.

50 E 18408

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gloria Wuester

(a) RESIDENCE NO. 424 S. Washington St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | white | single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) August 10/1926

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | | 5 | 17 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work XXXXX

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto. Md

PARENTS

10 NAME OF FATHER Christian L Wuester

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto., Md

12 MAIDEN NAME OF MOTHER Lillian Peckowski

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto. Md.

14 Informant Christian L. Wuester

(Address) 424 S. Wasington St.

26 1927 C. HAMPSON JONES, M. D.

Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27/1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Rectal Polypus With Obstruction

(Toxemia)

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) J. S. H. Owens M. D.

(Coroner)

1/27/27 (Address) 508 E. Norrn Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Hamlans. Date of Burial 1/28 1927

20 UNDERTAKER M. F. Sadow Ri. ADDRESS 705 N. Ann St

Very important—See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18409

## CERTIFICATE OF DEATH.

90 E 18409

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Emergency Home & Hero 16 & 26 ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carrie Boyd

(a) RESIDENCE No. 211 Rock. Ln ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Female | Colored | married |

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 24 | | | |

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cook
(b) General nature of industry, business, or establishment in which employed (or employer) Unknown
(c) Name of employer Unknown

BIRTHPLACE (city or town)
(State or country) Va

10 NAME OF FATHER Wm. Holmes

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER S Lomack

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

Informant Henry Holmes

(Address) 246 Rock Street

Filed JAN 28 1924, 192 HARRISON JONES, M. D.

By Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24th 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to her death by Laboulgar Disease of Heart (duration) yrs. mos. ds. on the day stated above.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Chas. Morrison M. D.
(Coroner.)

6/29, 192 7 (Address) 3632 Richardson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary DATE OF BURIAL June 28 1927

20 UNDERTAKER Leonard Whaley ADDRESS 7-9 Myrtle Ave

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 18410 — 162 — E 18410

1-PLACE OF DEATH

City of BALTIMORE: (No. 248 S. Duncan St., 12-3 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen M. Tate

(a) RESIDENCE NO. 248 S. Duncan St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~~Jan 1 27~~

6 DATE OF BIRTH (month, day, and year) Jan 1, 27

| 7 AGE | Years | Months | Days | IF LESS than 1 day ...hrs. or ...min. |
|---|---|---|---|---|
| | — | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md

(State or country)

PARENTS

10 NAME OF FATHER George S Tate

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Carroll Co. Md

12 MAIDEN NAME OF MOTHER M. N. Long

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto Md

14 Informant Geo. S. Tate

(Address) 248 S. Duncan

15 Filed ..... 19 C. HARPSON JONES, M. D. Registrar

By

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Jan 27 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

As Stated Dr

(duration) yrs. mos. 8 hrs. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 1 hr ds.

Jan 28 27 (Signed) G E Jones M. D.

(Coroner)

(Address) 1431 Biray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ...yrs., ...mos., ...ds. In the State ...yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn Date of Burial 1/28 1927

20 UNDERTAKER Wm Cook ADDRESS 502 E North

Very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18411

## CERTIFICATE OF DEATH

E 18411

REGISTERED NO. 27-53

1-PLACE OF DEATH

City of BALTIMORE: (No. 312 N Broadway St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Evelina Pitcherski

(a) RESIDENCE NO. 312 N Broadway St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 12-1926

7 AGE: Years 2 Months 2 Days 16

IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) ...

(State or country) Balto

PARENTS

10 NAME OF FATHER Charles Pitcherski

11 BIRTHPLACE OF FATHER (City or town) ...

(State or country) Balto

12 MAIDEN NAME OF MOTHER Alice M. Worden

13 BIRTHPLACE OF MOTHER (city or town) ...

(State or country) Balto

14 Informant Mrs Charles Pitcherski

(Address) 312 N Broadway

Filed JAN 28 1927 C. HARRISON JONES M. D. Registrar

Per —

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 28 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 18, 1927, to Jan 27, 1927,

that I last saw her alive on Jan 27, 1927,

and that death occurred, on the date stated above, at 2.45 a m.

The CAUSE OF DEATH* was as follows:

Whooping + Pneumonia

(duration) ... yrs. ... mos. 8 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) [illegible] M. D.

. 19 (Address) 3101 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Jan. 29 1927

Date of Burial

20 UNDERTAKER Dff & Cook

ADDRESS 1022 E. Fayette

Very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 18412

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18412

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Baltimore Gen. Hosp. ST. 4-25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edith Gallagher

(a) RESIDENCE NO. 644 W. Baltimore ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles F Gallagher

6 DATE OF BIRTH (month, day, and year): Nov 22 1907

7 AGE

| Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|
| 19 | 2 | 5 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Penna

PARENTS

10 NAME OF FATHER: A Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Bessie Keller

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/27 1927

17 I HEREBY CERTIFY, That I attended deceased from 1/21, 1927, to 1/27, 1927, that I last saw her alive on 1/27, 1927, and that death occurred, on the date stated above, at 3 30 P.m.

The CAUSE OF DEATH* was as follows:

Post partum sepsis at term.

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes. Date of 1/22/27

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Autopsy

(Signed) Charles F Jansen, M. D.

1/27, 1927 (Address) West Baltimore Gen. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

14 Informant (Address): West Baltimore Gen. Hosp

JAN 28 1927

HARRISON JONES, M. D. Registrar

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: Jan. 31 1927

20 UNDERTAKER: Joseph D Cook

ADDRESS: 1003 W. Balto St

Spec.—1-12-23—3M2—500 Blks.

1994

# HEALTH DEPARTMENT—CITY OF BALTIMORE

38 E 18413

## E 18413 CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ) ST. 22-6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Krumaska

(a) RESIDENCE No. 9 E. York ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

| 7 AGE Years | Months | Days | If LESS than 1 day, ...hrs or ...min. |
|---|---|---|---|
| 52 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia.

PARENTS

10 NAME OF FATHER Nicholas Krumaska

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia.

12 MAIDEN NAME OF MOTHER Mary Zamkovitz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Records

(Address)

15 Filed NOV 28 1927 C. HARRY JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 24 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan. 20 1927 to Jan. 24 1927.

that I last saw h alive on Jan. 24 1927

and that death occurred, on the date stated above, at 8 30 a.m.

The CAUSE OF DEATH* was as follows:

Aneurysm of the aorta

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Tracheal obstruction

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray

(Signed) E Coutts Andrus, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL Jan 27 1927

20 UNDERTAKER

ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18414 — 132E 18414

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. 9-26

CITY OF BALTIMORE: (No. Franklin Square Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2-FULL NAME Nathaniel Diggs.

(a) RESIDENCE NO. 51 Dennis Pl. ST., WARD Norfolk Va

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1901

7 AGE — Years: 26 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Norfolk Va

PARENTS

10 NAME OF FATHER John Diggs

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records

15 8 1927 C. HAMPSON JONES, M. D. Registrar

Per Robt

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/25/27 19

17 I HEREBY CERTIFY, That I attended deceased from 1/17/27, 19, to 1/25/27, 19,

that I last saw h[illegible] alive on 1/25/27, 19,

and that death occurred, on the date stated above, at 2.30 p. m.

The CAUSE OF DEATH* was as follows:

Ulcer in Bladder.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Post Operative Hemorrhage,

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? Yes Date of 1/19/27

Was there an autopsy? No

What test confirmed diagnosis? Hospital & Clinical

[redacted]ned) Unknown, M. D.

, 19 (Address) Baltimore & Druid.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Norfolk Va — DATE OF BURIAL: Jan 28 19[illegible]

UNDERTAKER: Samuel D. Smedley — ADDRESS: 5[illegible]8 M Baltimore

Cor.—12-9-25—A Co.—200 Bks.

White

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 18415

# CERTIFICATE OF DEATH.

E 18415

1-PLACE OF DEATH

City of BALTIMORE: (No. 525 E. Lang St. 18-26 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Vernon W Tate

(a) RESIDENCE NO. 525 E. Lang St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Infant

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec 13 / 26

7 AGE: Years / Months 13 Days: 6 weeks

IF LESS than 1 day ....hrs. or....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): Family

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Thadeus W Tate

11 BIRTHPLACE OF FATHER (city or town)

(State or country) N. C.

12 MAIDEN NAME OF MOTHER Viola Bunn

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) N. C.

14 Informant

(Address)

1927 C. HAMPSON JONES, M. D.

Per Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 1/28

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis,

Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) M. D.
(Coroner)

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.... yrs.... mos.... ds. In the State yrs.... mos.... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

Date of Burial: JAN 29 1927, 19

20 UNDERTAKER

ADDRESS

Commissioner Health

Very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18416 E 18416

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 903 University Parkway ST. 13-5-21 WARD)

REGISTERED NO. 91-04

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Parthenia Passano Baker

(a) RESIDENCE NO. 903 University Parkway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): Widow

5a If ~~married~~, widowed, or ~~divorced~~ ~~HUSBAND~~ of (or) WIFE of: Late William Baker Jr

6 DATE OF BIRTH (month, day, and year): March 4th 1845

7 AGE: Years 81 | Months | Days | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Lenord Passano

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER? Philip

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Mrs Baker

(Address): Catonsville

Filed 8 1927, 19 C. HAMPSON JONES, M. D., Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 28 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1926, to Jan 28, 1927.

that I last saw her alive on Jan 27, 1927.

and that death occurred, on the date stated above, at 1-7 m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary): Gangrene, L leg

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John A. Jones, M. D.

, 19 (Address) 1121 St. Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

DATE OF BURIAL: Jan 29 1927

20 UNDERTAKER: Percy Jenkins Co

ADDRESS: Eutaw & Fremont Sts

Spec.—1-12-23—M&T—500 Blks.

E 18417

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18417

## CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) 907 St Paul St (ST.) 11-15 (WARD)

2-FULL NAME Hammond J Dugan

(a) RESIDENCE NO. 907 St Paul St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, ~~widowed~~, or ~~divorced~~ HUSBAND of (or) ~~WIFE of~~ Agnes B. Dugan

6 DATE OF BIRTH (month, day, and year) March 30th 1864

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 62 | 9 | 27 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate

(b) General nature of industry, business, or establishment in which employed (or employer) Pierre C Dugan's

(c) Name of employer Nephew

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER C. Dugan

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Harriet Buckman

13 BIRTHPLACE OF MOTHER (city or town) Washington Co. Md (State or country)

14 Informant Mrs Nelson C Dugan

(Address) 51 N Fremont St

15 Filed JAN 28 1927 19 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27th 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec. 4th, 1926 to Jan 27th, 1927, that I last saw him alive on Jan 27th, 1927, and that death occurred, on the date stated above, at 8:15 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos 40 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Signs + Symptoms

(Signed) C. Hazard, M. D.

Jan 28th, 1927 (Address) 300 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL Jan 31 1927

20 UNDERTAKER Henry H Jenkins & Son

ADDRESS Walbrook Baltimore

Spec. -7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 18418

90 E 18418

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 912 S. Linwood ane St. 1-2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret A. Morris

(a) RESIDENCE NO. 912 S. Linwood ane St. Ward

(Usual place of abode) Life

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 22-1854

7 AGE: Years 72 Months 3 Days 5 LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto City

PARENTS

10 NAME OF FATHER: Edwin F Morris

11 BIRTHPLACE OF FATHER (City or town) (State or country): Balto Co

12 MAIDEN NAME OF MOTHER: Mary A Norris

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Co

14 Informant: Mrs Morris

(Address) 912 S. Linwood ane

15 8 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 January 27

17 I HEREBY CERTIFY, That I attended deceased from Nov 10" 1925, to January 27" 1927, that I last saw her alive on January 27" 1927, and that death occurred, on the date stated above, at 8. (P) m.

The CAUSE OF DEATH* was as follows:

Cardiac Decompensation

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Mitral & Aortic Insufficiency

(duration) 1 yrs. 2 mos. 16 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Calvert R Tilney, M. D.

Jan 28 1927 (Address) 100 S Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto County Date of Burial Jan 29 1927

20 UNDERTAKER: A S Marshall ADDRESS 3539 Fall Rd

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

18419

# HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 18419

## CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1301 N. Eden St., 9-17 Ward)

2-FULL NAME Mary Waggner

(a) RESIDENCE NO. 1301 N. Eden St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 10. 1857.

7 AGE: 70 Years 69 | Months 2. | Days 16 17. | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. W. 870

(b) General nature of industry, business, or establishment in which employed (or employer) — —

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore No1

(State or country)

PARENTS

10 NAME OF FATHER Lemuel Waggener

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto no.

12 MAIDEN NAME OF MOTHER Laura Phillips.

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country)

14 Informant Geo Delaney

(Address) 709. E. 22nd. St.

JAN 28 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/26 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan 25, 1927, to Jan 25, 1927, that I last saw h.. alive on Jan 25, 1927, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows: Cardiac Stenosis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible], M. D.

Jan 27, 1927 (Address) 1831 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — Date of Burial 1/29 1927

20 UNDERTAKER: George J Ruth — ADDRESS 1735 Harford ave

very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18420

E 18420

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. University Hospital St. H-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Asbury C. Rosier

(a) RESIDENCE NO. Towson R.F.D. 6 St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1 mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widowed of Mary Frances Rosier

6 DATE OF BIRTH (month, day, and year): May 3rd. 1857

| 7 AGE | Years | Months | Days | IF LESS than 1 day ... hrs. or ... min. |
|---|---|---|---|---|
| | 69 | 8 | 23 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): Own

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) County

10 NAME OF FATHER Thos S. Rosier

11 BIRTHPLACE OF FATHER (City or town) (State or country) Penna.

12 MAIDEN NAME OF MOTHER Harriett Parsons

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

PARENTS

14 Informant: Mrs. Charles N. McLain

(Address) Harford Rd. Towson RFD 6

15 C. HAMPSON JONES, M. D.

1927 Per ... 19 ... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 26th 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec. 27, 19 26, to January 26, 19 27,

that I last saw h alive on Jan. 26, 19 27,

and that death occurred, on the data stated above, at 10 20 p. m.

The CAUSE OF DEATH* was as follows:

Prostatic hypertrophy with obstruction due to occlusion of vesical orifice

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Uremia

Pulmonary Oedema

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Data of

Was there an autopsy? No

What test confirmed diagnosis? Cystoscopic Examination

(Signed) Jacob R. Jensen, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. Date of Burial: Jan. 29, 27

20 UNDERTAKER: Wm J. Tickner & Sons ADDRESS: North Ave

very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18421 E 18421

## CERTIFICATE OF DEATH.

16-22 44

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 904 (ST.) Woodley (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter E Brookes

(a) RESIDENCE NO. 904 (ST.) Woodley (WARD)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Laura V Brookes

6 DATE OF BIRTH (month, day, and year): Dec 29-1856

7 AGE — Years: 70 — Months: — — Days: 26 — If LESS than 1 day, ..... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Printer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: James Brookes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not known

14 Informant: Laura V. Brookes (Address) 904 Woodley St

15 Filed ..... 19 ..... Per ..... Registrar

C. HAMPSON JONES, M. D.

8 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 25 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov. 11, 1926, to January 26 1927, that I last saw him alive on Jan. 25, 1927, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Carcinomatosis Peritonei

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Carcinoma of Cardia and Stomach

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray

(Signed) F. H. Leonard, M. D.

, 19 (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cemetery — DATE OF BURIAL: Jan 29 1927

20 UNDERTAKER: Henry Lutz — ADDRESS 1203 N. Broadway

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18422

## CERTIFICATE OF DEATH.

57

E 18422

1-PLACE OF DEATH

CITY OF BALTIMORE; (No.) 942 W Gay St (St.) Balto (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John E Lunsford

(a) RESIDENCE NO. 942 W Gay St (ST.) Balto (WARD)

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | Married |

5a If married, widowed, or divorced HUSBAND of or) WIFE of Sallie Lunsford

6 DATE OF BIRTH (month, day, and year) Dec 17 1866

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs. or ....min. |
|---|---|---|---|---|
| | 60 | 1 | 10 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B C & A R R

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER W^m Lunsford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Richmire

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Dr Murray

(Address) 510 N. Fremont Ave

15 Filed 8 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 20 1926 to Jan 27 1927

that I last saw him alive on Jan 27 1927

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Apoplexy). Patient had two attacks first 12/20/26, Secnd 1/25/27 (duration) yrs. 1 mos 7 ds.

CONTRIBUTORY (Secondary) Diabetes (duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. Mc Edwards M. D.

, 19 (Address) 2738 Alameda Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem

DATE OF BURIAL Jan 28 1927

20 UNDERTAKER W^m Cook

ADDRESS 502 North Ave

Spec.—1-10-21—M&T—1500 Bks.

E 18423

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 18423

REGISTERED NO. 11-2665

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. Maryland General Hospital ST., WARD)

2-FULL NAME Rev. George Clarke Peck.

(a) RESIDENCE NO. Maryland General Hospital ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kate Marshall Peck.

6 DATE OF BIRTH (month, day, and year) Sept 13, 1866

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 60 | 4 | 14 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clergyman & General Superintendent

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Md. Gen. Hosp.

9 BIRTHPLACE (city or town) (State or country) Mass.

PARENTS

10 NAME OF FATHER Rev. James O Peck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mass.

12 MAIDEN NAME OF MOTHER Sue Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mass.

14 Informant Mrs. W. W. Gatch

(Address) 2600 W. Calvert St.

15

8 1927 C. HAMPSON JONES, M. D. Registrar

By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 27 1927

17

I HEREBY CERTIFY, That I attended deceased from December 1, 1925, to January 27, 1927, that I last saw h[im] alive on January 27, 1927, and that death occurred, on the date stated above, at 6.50 P. m.

The CAUSE OF DEATH* was as follows:

Myelogenous leukemia.

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic & laboratory findings

(Signed) Chas. Wilbur Stewart M. D.

1/27 1927 (Address) 1738 E. 28th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL Feb 1 1927

20 UNDERTAKER Wm Cook

ADDRESS 502 E North Ave

E 18424

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18424

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Md General Hospital ST.; WARD.)

REGISTERED No. C 11328

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Millard M. Meyick (Salisbury Md)

(Residence in Baltimore: No. none St.; yrs.; mos. 1 ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

| 3-SEX, | 4-COLOR OR RACE, | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) |
|---|---|---|
| Male | White | married |

6-DATE OF BIRTH, Dec 11, 1870 (Month) (Day) (Year)

7-AGE, 56 yrs. 1 mos. 17 ds. If LESS than 1 day, ....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) O/W

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Isaac Meyick

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Elizabeth White

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gurney H. Meyick

(Address) Fruitland Md.

15- C. HAMPSON JONES, M. D.

Filed 2 8 1927, 191.... Per ..... Registrar.

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 28, 1927 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Physician (Fracture of Left arm & leg)

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Drowned on Steamer Dow

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D. (Coroner)

Jan 28 1927 (Address) 2807 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

| 19-PLACE OF BURIAL OR REMOVAL, | DATE OF BURIAL, |
|---|---|
| Salisbury Md | ....., 192.. |
| 20-UNDERTAKER Henry P. Watkins Sons | ADDRESS 1 Mitchell Court |

Important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18425

## CERTIFICATE OF DEATH

49E-18425

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 449 Illchester St., Ward 12-50

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Lentz

(a) RESIDENCE NO. 749 Illchester St Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Josiah A Lentz

6 DATE OF BIRTH (month, day, and year): May 28, 1872

7 AGE: Years 54 Months 8 Days

IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER: John Stricker

11 BIRTHPLACE OF FATHER (City or town): Md

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town): Md

(State or country)

14 Informant: J. A. Lentz

(Address) 0449 Illchester St

29 1927 C. HAMPSON JONES, M. D. Registrar

Per ARH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 28, 19 27

17 I HEREBY CERTIFY, That I attended deceased from Oct 2nd, 19 26, to Jan 28th, 19 27,

that I last saw her alive on Jan 27th, 19 27,

and that death occurred, on the date stated above, at 3.30 A.m.

The CAUSE OF DEATH* was as follows:

Adeno - Carcinoma

of Right Kidney

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) ?

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Yes Date of Oct 5/26

Was there an autopsy? No

What test confirmed diagnosis? Laboratory Exam.

(Signed) Geo. W. Epperson M. D.

1/28 19/27 (Address) 401 E 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — Date of Burial: Jan 31 1927

20 UNDERTAKER: Chenowith & Son — ADDRESS: 2617 Chestnut

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18426

## CERTIFICATE OF DEATH

3 | E 18426

REGISTERED NO. 27-320

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Ziginski

(a) RESIDENCE NO. 640 W. Conway St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. da. How long in U. S. if of foreign birth 41 yrs. mos. da.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| M | W | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — No. 1870

6 DATE OF BIRTH (month, day, and year)

7 AGE 57 Years — Months — Days — IF LESS than 1 day ...hrs. or ...min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Lithvania

(State or country)

PARENTS

10 NAME OF FATHER No.

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Lithvania

12 MAIDEN NAME OF MOTHER No.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Lithvania

14 Informant Lillian Ziginski

(Address) 640 W Canaway St.

15 Filed JAN 29 1927 HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan, 28 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 27, 1927 to Jan 28, 1927

that I last saw him alive on Jan 28, 1927

and that death occurred, on the date stated above, at 4 A M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 8 mos. da.

CONTRIBUTORY (Secondary) Bronchial pneumonia

(duration) yrs. mos. 2 da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Edwin M. Edwards, M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Holy Redeemer | Jan. 31. 1927 |
| **20 UNDERTAKER** | **ADDRESS** |
| John Grebliauckas & Co. | 423 S Paca |

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 18427

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18427

## CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1505 N. Eden St. ST., 9-17 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stephen A. Lusby

(a) RESIDENCE NO. 1505 N. Eden St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes Lusby

6 DATE OF BIRTH (month, day, and year) Dec 26th 1853

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 73 | 1 | 2 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer): O'11

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard Co. Md.

PARENTS

10 NAME OF FATHER Samuel Lusby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington, D. C.

12 MAIDEN NAME OF MOTHER Georgiana Chaney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Mrs Ina Lusby (Address) 1506 N Eden St

15 Filed 2 9 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 28, 19 27

17

I HEREBY CERTIFY, That I attended deceased from Jan. 23, 19 27, to Jan. 27, 19 27,

that I last saw h im ve on Jan. 27, 19 27

and that death occurred, on the date stated above, at 6:40 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia (lobar) 5 Day

Chronic Myorcarditis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ear Mendelson, M. D.

1/28, 1927 (Address) 24 N. Fulton Ave.,

*State the Disease Causing Death, as in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery

DATE OF BURIAL Jan 31st 1926

20 UNDERTAKER George Schilling & Sons

ADDRESS 1126 E Monument

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18428 E 18428

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Balto City Hospitals (REGISTERED NO. 38)

CITY OF BALTIMORE: (NO. Balto, Md 14-70 WARD)

2-FULL NAME Estelle Tasker

(a) RESIDENCE NO 1832 Division St., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Blk

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1887.

7 AGE: Years 40 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Telephone Operator

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: David Tasker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Donna Douglass

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Balto City Hosps Balto Md

15 1927 C. HARRISON JONES, M. D. Registrar

No. ——— ditto

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-27 1927

17 I HEREBY CERTIFY, That I attended deceased from 12-7- , 1926, to 1-27 , 1927

that I last saw her alive on 1-26 , 1927

and that death occurred, on the date stated above, at 540 A. m.

The CAUSE OF DEATH* was as follows:

General Paralysis of Insane
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Luetic Infection
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. W. Goldsmith M. D.

19 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn cemetery

DATE OF BURIAL: 1/31 1927

20 UNDERTAKER: Mrs Jas H. Dennis' in T. Gilmanson

ADDRESS: 1303 Pleasant St.

FROM a very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 18429

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18429

## CERTIFICATE OF DEATH.

16-22

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1150. N. Stricker (St.) (16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes E. Mason

(a) RESIDENCE. NO. 1150. N Stricker ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Fem | Col | Married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Thomas G. Mason

6 DATE OF BIRTH (month, day, and year) Apr -1880

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 46 | 9 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Aaron Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary A. Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Thomas G. Mason
(Address) 1150. N. Stricker

15 Filed JAN 29 1927 G. HAMPSON JONES, M. D., Registrar.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 28 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 1926, to Jan 1927,
that I last saw h.e.r. alive on Jan 26, 1927,
and that death occurred, on the date stated above, at 8:30 A m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) 3 hrs. mos. ds.

CONTRIBUTORY (Secondary) Cirhosis Liver

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Don't know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? the usual one

(Signed) H. G. Nye, M. D.

1/29 1927 (Address) Edgewood Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL Jan 29 1927

20 UNDERTAKER Wm H. Case & Son

ADDRESS 1400 Madison

JAN 29 1927 APP.

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18430

## CERTIFICATE OF DEATH.

118 E 18430

REGISTERED NO. 13-52

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: Maryland General Hospital ST., WARD

2-FULL NAME Selwyn L. Briscoe

(a) RESIDENCE NO. 822 W 36th St., ST., 23 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. 10 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3-10-1909

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 17 | 10 | 17 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Pupil

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Walter L. Briscoe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah B. Stanley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Walter Briscoe Dad

(Address)

15 Filed FEB 3 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-27-1927

17 I HEREBY CERTIFY, That I attended deceased from 1-26-27, 19..., to 1-27-27, 19..., that I last saw h/M alive on 1-27-27, 19..., and that death occurred, on the date stated above, at 4:56 A.m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction due to Meckles Diverticulum

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 1-26-27

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) C. C. Zimmerman, M. D.

, 19 (Address) Md. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| St. Mary's Frankdm | Jan 31 1927 |
| 20 UNDERTAKER | ADDRESS |
| Horace A. Burgee | Glen Falls Md |

TION IS very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 18431 HEALTH DEPARTMENT—CITY OF BALTIMORE E 18431

41

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1310 (St.) Pennsylvania Ave (WARD) 17-24

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie Phillips

(a) RESIDENCE No. 1310 Pennsylvania Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced (or) WIFE of Corpus Phillips

6 DATE OF BIRTH (month, day, and year) Jan 15 1899

7 AGE Years 28 Months Days 10 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Sumter S.C.

PARENTS

10 NAME OF FATHER Henry Prescott

11 BIRTHPLACE OF FATHER (city or town) (State or country) S.C.

12 MAIDEN NAME OF MOTHER Ella Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S.C.

14 Informant Chas Phillips

(Address) 1310 Penna Ave

Filed 1-29 1927 C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 30 1926 to Jan 25 1927

that I last saw her alive on Jan 25 1927

and that death occurred, on the date stated above, at 10.50 a.m.

The CAUSE OF DEATH* was as follows:

Leukemia (Non Surgical)

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Hemorrhage Jaw (duration) yrs. mos. 26 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic Examination

(Signed) W. C. Rowell M.D.

1-28-27 (Address) 1621 Carrollton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL Jan 29 1927

20 UNDERTAKER Sam'l. Case Son

ADDRESS 1400 Mosher

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 18432

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18432

## CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 146 Colvin ST. 5-8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel St. Vincent Parkinson

(a) RESIDENCE NO. 146 Colvin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| m | c | S |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 16, 1918

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs. or ....min. |
|---|---|---|---|---|
| | 8 | 7 | 11 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) School

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Daniel St. V. Parkinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Jamaica B.W.I.

12 MAIDEN NAME OF MOTHER Georgiana Webster

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mother
(Address) 146 Colvin

15 Filed 9 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 27 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 15, 1927, to Jan. 27, 1927, that I last saw him alive on Jan. 27, 1927, and that death occurred, on the date stated above, at 5:30 A.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Phys. Exa.

(Signed) W. L. Raffety, M. D.

, 19 (Address) 1520 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem.

DATE OF BURIAL Jan 31 1927

20 UNDERTAKER Mrs J. G. Locke

ADDRESS 1302 Jefferson

Spec.–7-17-26—A Co.—200 Bks.

E 18433

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18433

## CERTIFICATE OF DEATH

100-001

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hospital St., 20 Ward)

REGISTERED NO. 20-64

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Joseph Du Chesney

(a) RESIDENCE NO. 431 East Lynn St. 20 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. 5 mos. 28 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 29th 190[illegible]

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|---|
| | 24 yrs | 5 mos | 28 ds | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur 021

(b) General nature of industry, business, or establishment in which employed (or, employer) Yellow Cab

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER not given

11 BIRTHPLACE OF FATHER (City or town)

(State or country) " "

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) " "

14 Informant Mrs Graff

(Address) 622 S. Fulton Ave.

FILED JAN 29 1927 C. HAMPSON JONES, M. D. Registrar

By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

January 26 - 1927

I HEREBY CERTIFY, That I attended deceased from 12-21, 1926, to 1-26, 1927.

that I last saw him alive on 1-26, 1927.

And that death occurred, on the date stated above, at 8 40 P m.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency and Bronchopneumonia - J

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Emphysema

(duration) yrs. 1 mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) Sherman Hunter M. D.

1/26. 1927 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

Date of Burial 1927

20 UNDERTAKER: F. O. Whitehurst

ADDRESS 1850 W. Baltimore St.

OF DEATH in plain terms, so that it may be very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 18434 HEALTH DEPARTMENT—CITY OF BALTIMORE E 18434

22

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 404 N Pine St., 17 Ward)

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jerry Greene

(a) RESIDENCE NO. 404 N Pine ST., WARD _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., If of foreign birth? ___ yrs. ___ mos. ___ ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced, (HUSBAND of or) WIFE of: Eleanora Greene

6 DATE OF BIRTH (month, day, and year): - - 1895

7 AGE — Years: 32 — Months: - — Days: - — If LESS than 1 day, ___ hrs. or ___ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): ———

(c) Name of employer: ———

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: James Green

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Annie Barnes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Alice Bolden

(Address): 404 N Pine St

JAN 29 1927 C. HAMPSON JONES, M. D. Registrar

Per _____ Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jany 27 1927

17 I HEREBY CERTIFY, That I attended deceased from Jany 18, 1927, to Jany 27, 1927, that I last saw him alive on Jany 26, 1927, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Acute Myelitis over

(duration) ___ yrs. ___ mos 20 ds.

CONTRIBUTORY (Secondary) _____ (duration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted if not at place of death? ———

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Negative

(Signed) W. J. Wells, M. D.

1/28 1927 (Address) 119 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: Jan 29 1927

20 UNDERTAKER: Leonard Whalen 3 09

ADDRESS: My Dear

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

John F. Allender

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18435 — 188 — E 18435

## CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. University Ave St., 4-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John F Allender

(a) RESIDENCE NO. Lyndon md St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Allender

6 DATE OF BIRTH (month, day, and year) July 4 1856

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 70 | 11 | 23 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) 186

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Co

(State or country) md

PARENTS

10 NAME OF FATHER Thomas J Allender

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Not known

12 MAIDEN NAME OF MOTHER Rebecca Tea

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Not known

14 Informant Edward Allender

(Address) Glyndon Balto Co md

15 Filed 1927 By RRR

C. HAMPSON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/27 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Fall from wagon at Glyndon struck head

Trade

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fracture of Skull

(duration) yrs. mos. ds.

(Signed) Hamil S Fisher M. D.

(Coroner)

, 19 27 (Address) 3525 Park Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Asbury M E Cemetery Jan 30 1927

20 UNDERTAKER — ADDRESS

J F Edwin & Sons Reisterstown md

29 1927

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18436

90 E 18436

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 704 Cumberland St. 15-21 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bertha Blake

(a) RESIDENCE NO. 704 Cumberland St. — Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 Color or Race: colored | 5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of Hillary Blake

6 DATE OF BIRTH (month, day, and year): about 1895

7 AGE: Years 32 | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Md

PARENTS

10 NAME OF FATHER Samuel Penn

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Md.

12 MAIDEN NAME OF MOTHER Betty Combs.

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Md.

14 Informant: Hillary Blake

(Address) 704 Cumberland St.

15 FILED: JAN 29 1927 19

C. HAMPSON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 26 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) no history

(duration) yrs. mos. ds.

(Signed) D. T. Hennessy M. D. (Coroner)

1/27, 192 (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn | Date of Burial: Jan 29 '27

20 UNDERTAKER: Virginia A. Brooks | ADDRESS: 1439 Carey

Duplicate. Fees, statement of occupation is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18437

## CERTIFICATE OF DEATH.

100 E 18437

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2509 Jefferson St. 6-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maria Louisa Swazey

(Residence in Baltimore: No. 2509 Jefferson St.; 61 yrs., mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, April 14, 1866
(Month) (Day) (Year)

7-AGE, 77 yrs. 9 mos. 14 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Richmond Va

PARENTS.

10-NAME OF FATHER, Jordon Butler

11-BIRTHPLACE OF FATHER (State or Country) Richmond Va

12-MAIDEN NAME OF MOTHER Eliza Beth Edwards

13-BIRTHPLACE OF MOTHER (State or Country), Richmond Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Katherine Lester

(Address) 123 W Chelsea Av

15- C. HAMPSON JONES, M. D.

Filed 9 1927 191 Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 28, 1927
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from January 26 1927, to January 28 1927, that I saw her alive on January 27 1927, and that death occurred, on the date stated above, at 2.40 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. A. Broadbent M. D.

Jan 28, 1927 (Address) 1220 E Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Oak Lawn Cemetery

DATE OF BURIAL. Jan. 31, 1927

20-UNDERTAKER Robt J Turner & Sr

ADDRESS N Broadway

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18438

## CERTIFICATE OF DEATH.

× 49

E 18438

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Mercy Hospital

City of BALTIMORE: (No. _____ St., 4-7 ward)

2-FULL NAME John Prosser Tabb

(a) RESIDENCE NO. Middleburg, Va. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: White

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~. (write the word): Widower

5a If ~~married~~, widowed, or ~~divorced~~ ~~HUSBAND~~ of ~~WIFE~~

6 DATE OF BIRTH (month, day, and year): Nov 27 1854

7 AGE: Years 72. Months 2 Days 2 IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country) Virginia

PARENTS

10 NAME OF FATHER John Prosser

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Rebecka Lloyd

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Virginia

14 Informant Mrs George Mackenbin

(Address) 14 E Lanvale St

15 Filed 1 29 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 29 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 8, 1927, to Jan 29, 1927

that I last saw h~~e~~r alive on Jan 29, 1927

and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Cystoscopic Metastasis

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) P. Gillette, M. D.

1/29, 1927 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Middleburg Loudon Co Va

Date of Burial: Jan 30 1927

20 UNDERTAKER: Henry A Jenkins & Sons Co

ADDRESS: Cathedral & Mulberry

Certificate of death in plain terms, as full as may be properly required. Every statement is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18439 — 161-09 — E 18439

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1217 E. Preston St. 10-14 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Donald Eugene Tierney

(a) RESIDENCE NO. 1217 E. Preston St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 Color or Race: White.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Jan 20th 1927

7 AGE — Years: 8 days. Months: — Days: 9 IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md.

PARENTS

10 NAME OF FATHER: Thomas Edwin Tierney

11 BIRTHPLACE OF FATHER (city or town): Baltimore

(State or country): Md

12 MAIDEN NAME OF MOTHER: Pearl Elizabeth Musick

13 BIRTHPLACE OF MOTHER (city or town): Mount Royal

(State or country): Va.

14 Informant: Mrs. Thomas Edwin Tierney

(Address): 1217 E. Preston St.

29-1927 C. HAMPSON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): January 29th 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 10th, 1927, to Jan 29th, 1927, that I last saw h.xxx alive on Jan 28th, 1927, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Miller White, M. D.

Jan 29 1927. (Address) 3605 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem. Date of Burial: Jan 29 1927

20 UNDERTAKER: Ehrenowetz & Son ADDRESS: 3617 Chestnut Av

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18440

## CERTIFICATE OF DEATH.

49

E 18440

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 904 St. Paul ST. 11-15 WARD)

2-FULL NAME Frank G. Edmondson

(a) RESIDENCE NO. 904 St. Paul ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 6 mos. 11 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine Waters

6 DATE OF BIRTH (month, day, and year) July 17, 1874

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 52 | 6 | 11 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bank Teller 09

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balto. Commercial Bank

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER W. Winder Edmondson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Hooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant (Address) Mrs. Katherine W. Edmondson 904 St. Paul Street

15 Filed JAN 30 1927, 19 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 28 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov, 1925, to Jan 28, 1927, that I last saw him alive on Jan 27, 1927, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the neck

(duration) 1 yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Feb 1926

Did an operation precede death? Yes Date of May 1926

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) Geo. B. Hawkins, M. D.

, 19 (Address) 5835 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery

DATE OF BURIAL 1/31 19 27

20 UNDERTAKER Henry U. Mears & Son

ADDRESS 1805 N. Calvert

THIS IS very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

**E 18441**
1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

51 ✓

**E 18441**
REGISTERED NO.

City of BALTIMORE: (No. 1306 N. Montford Ave 8-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine V. Whittington

(a) RESIDENCE NO. 1306 N. Montford Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 Color or Race: White
5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 20/1923

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 3 | 10 | 8 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Thomas Whittington
11 BIRTHPLACE OF FATHER (city or town)
(State or country): Baltimore
12 MAIDEN NAME OF MOTHER: Florence Fink
13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Baltimore

14 Informant: Thomas Whittington
(Address): 1306 N. Montford Ave.

15 Filed ..... 19..... Registrar

30 1927 — L.H.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 28 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1927, to Jan 28, 1927,
that I last saw h[illegible] alive on Jan 28, 1927,
and that death occurred, on the date stated above, at 7 [illegible] m.

The CAUSE OF DEATH* was as follows:
Endocarditis with Cardiac & Respiratory Paralysis
(duration) ..... yrs. ..... mos. 1 ds.
CONTRIBUTORY (Secondary): Arthritis Multiplex
(duration) ..... yrs. ..... mos. 28 ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Physical Signs
(Signed) [illegible] M. D.
Jan 29, 1927 (Address) 130 N Patapsco

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem. Date of Burial Jan 31 1927

20 UNDERTAKER: Frank A. Fink ADDRESS: 915 N. Gay St

very important. See instructions on back of certificates.

Spec.—1-12-23—M.C.—500 Bks.

1995 26

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18442

## CERTIFICATE OF DEATH.

101-001

E 18442

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ) ST., 7-9 (WARD)

2-FULL NAME Robert Gowell

(a) RESIDENCE NO. 910 - 4th St. Sparrows WARD Pt - Md -
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | | 9 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md -

PARENTS

10 NAME OF FATHER Andrew Gowell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va -

12 MAIDEN NAME OF MOTHER Josephine Denlon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md -

14 Informant Records.
(Address) JOHNS HOPKINS HOSPITAL

30 1927
Filed , 19

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 28 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 23, 1927, to Jan 28, 1927, that I last saw h[illegible]live on Jan 28, 1927 and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Acute primary pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) Hermes W Conwell M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Oak Lawn Cemetery | 1/30/27 |
| 20 UNDERTAKER | ADDRESS |
| Joseph Ahrens | 221 Ruxay |

SEE INSTRUCTIONS ON BACK OF CERTIFICATES. IT IS VERY IMPORTANT

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18443 — 10-002 — E 18443

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital 926-37 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lorraine Blondheim

(a) RESIDENCE No. 3423 E. Pratt St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. 2 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 22. 1918

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 8 | 2 | 8 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Albert Blondheim

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Lula Livingston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Albert Blondheim

(Address) 3423 E. Pratt St-

15 Filed 1-30 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 23, 1927, to Jan 29, 1927.

that I last saw her alive on Jan 29, 1927.

and that death occurred, on the date stated above, at 7.15 a m.

The CAUSE OF DEATH* was as follows:

Tons. & Pharyn. Diphtheria

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis Clinical & Bac. Culture

(Signed) Myron G. Tull, M. D.

1/29 1927 (Address) Sydenham Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn Cemetery

DATE OF BURIAL Jan. 30 1927

20 UNDERTAKER Zirkler & Zirkler

ADDRESS 1739 E. Eager St.

TION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18444

## CERTIFICATE OF DEATH.

100-001

E 18444

1-PLACE OF DEATH Res - Mt Royal. REGISTERED NO.

CITY OF BALTIMORE: (No. Mount Royal Hotel ST., 11-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Adams Aiken

(a) RESIDENCE NO. 30 Orchard ST., Greenfield, Massachusetts
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Maria Dickinson Aiken

6 DATE OF BIRTH (month, day, and year) September 16, 1850

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs or ... min. |
|---|---|---|---|---|
| | 76 | 4 | 12 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer) 042

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Greenfield, Mass.

PARENTS

10 NAME OF FATHER David Aiken

11 BIRTHPLACE OF FATHER (city or town) Londonderry (State or country) New Hampshire

12 MAIDEN NAME OF MOTHER Elizabeth Adams

13 BIRTHPLACE OF MOTHER (city or town) Amherst, (State or country) Mass.

14 Informant (Address) John Dickinson 1125 St. Paul St.

15 Filed ... 19... C. HAMPSON JONES, M. D. Registrar

JAN 30 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 28th 1927.

17 I HEREBY CERTIFY, That I attended deceased from Jan. 18th, 1927, to Jan. 27th, 1927, that I last saw him alive on Jan. 27th, 1927, and that death occurred, on the date stated above, at 7.10 A.m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) J. Clay Parran M. D.

Jan 28th 1927 (Address) Mt. Royal Hotel

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Loudon Park Cem | Jan 31st 1927 |
| UNDERTAKER Henry A. Watkins Sons Co | ADDRESS McCulloh & Richards |

THIS IS very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18445

## CERTIFICATE OF DEATH

90

16-69

REGISTERED NO. E 18445

1-PLACE OF DEATH

City of BALTIMORE: (No. 2716 Edmondson Ave. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Kratz,

(a) RESIDENCE NO. 2716 Edmondson Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Augusta Kratz,

6 DATE OF BIRTH (month, day, and year) September 12.1858

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min.. |
|---|---|---|---|---|
| 65 | 67 | 4 | 16 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cashier

(b) General natore of indostry, business, or establishment in which employed (or employer) 009

(c) Name of employer Southern Hotel

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Kratz,

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Vogelsang

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore.Md.

14 Informant Mrs Augusta Kratz

(Address) 2716 Edmondson Ave.

15 Filed JAN 30 1927, 19 C. HAMPTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JAN 23 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 20, 1927, to Jan. 25, 1927, that I last saw him alive on Jan. 25, 1927, and that death occurred, on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease.

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. J. Kenney, M. D.

1/28, 19 27 (Address) 2802 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

Date of Burial JAN 31 1927 19

20 UNDERTAKER Geo W Little

ADDRESS 2900 EDMONDSON AVE

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18446

## CERTIFICATE OF DEATH.

31

REGISTERED NO. E 18446

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1127 N. Mount ST. 16-22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Calvert Galaway

(a) RESIDENCE No. 1127 N. Mount ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Col | married |

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Clara Galaway

6 DATE OF BIRTH (month, day, and year) Aug. 6 - 1844

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 37 | 5 | 21 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal & wood

(b) General nature of industry, business, or establishment in which employed (or employer) business

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Calvert Co. Md.

PARENTS

10 NAME OF FATHER Fielder Galaway

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co. Md.

12 MAIDEN NAME OF MOTHER Margaret Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co. Md

14 Informant Gertrude McMurray (sister) (Address) 1211 Harlem Ave.

15 Filed JAN 30 1927, 19 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 27 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec. 28, 1926, to Jan. 27, 1927, that I last saw h in alive on Jan. 26, 1927, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Tuberculosis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? T.B. Bacilli isolated

(Signed) Paul Brown M. D.

1/27 1927 (Address) 1837 Penna. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: Jan 30 1927

20 UNDERTAKER Daniel Easton — ADDRESS 916 Eutaw

TION is very important See instructions on back of certificates.

Spec.—12 9 25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18447

## CERTIFICATE OF DEATH.

101-001

E 18447

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

REGISTERED NO.

City of BALTIMORE: (No.) [redacted] St. 18-26 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carroll Williams

(a) RESIDENCE NO. 1120 W Saratoga St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Negro | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Williams

6 DATE OF BIRTH (month, day, and year) 1898

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 29 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) D 40

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph Williams

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Carrie —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant

(Address) Records

JAN 30 1927 HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 28 1927

17

I HEREBY CERTIFY, That I attended deceased from January 26 1927, to January 28, 1927, that I last saw h.. alive on January 28, 1927, and that death occurred, on the date stated above, at 9.45 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? general & Laboratory

(Signed) C. Hoppe Smith, M. D.

Jan 29 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Date of Burial Jan 30 1927

20 UNDERTAKER Daniel Easton ADDRESS 916 Eutaw

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 18448

## CERTIFICATE OF DEATH.

E 18448

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 1110 Duke Alley St. 3-5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sadie Reed

(a) RESIDENCE NO. 1110 Duke Alley St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Colored | Married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1886

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 41 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Nabolian Reed

(Address) 1110 Duke St

Filed JAN 30 1927 C. HARRISON JONES, M. D. Registrar

Per _____

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ____ yrs. ____ mos. ____ ds.

Jan 28 27 (Signed) W. C. Todd M. D.

(Coroner)

(Address) 143 W. Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem Date of Burial Jan 30 1927

20 UNDERTAKER Hamilton Easton ADDRESS 946 Park.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

74-001

E 18449 REGISTERED NO.

E 18449
1-PLACE OF DEATH

City of BALTIMORE: (No. 709 S. Ellwood Ave St. 1-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Clara Smith

(a) RESIDENCE NO. 934 S. East Ave. St. Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of David M. Smith

6 DATE OF BIRTH (month, day, and year) Aug 10 - 1860

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min.. |
|---|---|---|---|---|
| | 66 | 5 | 17 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) at home
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS
10 NAME OF FATHER Nicolas Dimmick
11 BIRTHPLACE OF FATHER (City or town)
(State or country) Germany.
12 MAIDEN NAME OF MOTHER Unknown.
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany.

14 Informant David M. Smith
(Address) 934 S. East Ave

15 Filed JAN 30 1927 16 C. HARRISON JONES, M. D. Registrar
By RH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 27 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 15 1924, to Jan 27 1927, that I last saw h aliva on Jan 26 1927, and that death occurred, on the date stated above, at 12.55 a. m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(duration) yrs. mos. 3 hrs. da.

CONTRIBUTORY (Secondary) arterio-sclerosis-Hypertension
(duration) years yrs. mos. da.

18 Where was disease contracted
If not at place of death?
Did an operation precede death? Data of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Nathan J. Landow, M. D.
, 19 (Address) 3035 O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. Jan 31 st 1927 — Date of Burial

20 UNDERTAKER Lilly & Jailer — ADDRESS 403 S. Wolfe St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Bunjon

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 18450

E 18450

## CERTIFICATE OF DEATH.

REGISTERED NO. 12-51

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2235 Huntingdon Ave St. WARD)

2-FULL NAME Roland N. Bunjon

(a) RESIDENCE No. 2235 Huntingdon Ave St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6 DATE OF BIRTH (month, day, and year): June 28-1926

7 AGE — Years: — Months: 7 Days: 1 If LESS than 1 day, hrs or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto City.

PARENTS

10 NAME OF FATHER: Dominic Bunjon

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Pauline Decker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Pauline Decker

(Address): 2235 Huntingdon Ave

JAN 30 1927

C. HAMILTON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1-29 1927

17 I HEREBY CERTIFY, That I attended deceased from 1-26, 1927, to 1-29, 1927.

that I last saw him alive on 1-28, 1927,

and that death occurred, on the date stated above, at 8 AM m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C Hamilton Jones, M. D.

1-29, 1927 (Address) 2201 Reisterstown Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Vincent Cemetery

DATE OF BURIAL: Jan 31 1927

20 UNDERTAKER: J S Marshall

ADDRESS: 3539 Fall Rd

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 18451 HEALTH DEPARTMENT—CITY OF BALTIMORE E 18451

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1802 Druid Hill ave ST.: 14-20 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thos. H. Buckingham

(a) RESIDENCE. No. 1802 Druid Hill ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Medota Buckingham

6 DATE OF BIRTH (month, day, and year): 1875

7 AGE: Years 52; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Barber

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Kensington Ohio.

PARENTS

10 NAME OF FATHER: Calhoon

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ohio

12 MAIDEN NAME OF MOTHER: Clukaver

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Medota Buckingham (Address) 1802 Druid Hill ave

15 Filed JAN 30 1927 C. HARRISON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 26 - 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 11 - 1927, to Jan 26 - 1927, that I last saw h... alive on Jan 26 - 1927, and that death occurred, on the date stated above, at 9:10 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage
with right sided hemiplegia

(duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary): Arterio sclerosis probably (duration) 5 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Chas. J. Keller, M. D.

1/27, 1927 (Address) 222 W. Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem. DATE OF BURIAL: Jan 30 '27

20 UNDERTAKER: Edmund D. Hensley ADDRESS: Belle

TION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18452

## CERTIFICATE OF DEATH

11-002

E 18452

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1025 E. Madison St. 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Perry Fairwright

(a) RESIDENCE NO. 1025 E. Madison St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charity Wright

6 DATE OF BIRTH (month, day, and year) 1876

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min.. |
|---|---|---|---|---|
| | 51 | 50 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER Charles Wright

11 BIRTHPLACE OF FATHER (City or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Charity Wright

(Address) 1025 E. Madison St.

15 Filed JAN 30 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec. 31, 1927 to Jany 28, 1927 that I last saw him alive on Jany 29, 1927 and that death occurred, on the date stated above, at 1.30 A. m.

The CAUSE OF DEATH* was as follows:

Ac. Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank E. Wagner M. D.

1/29 1927 (Address) 1106 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery Date of Burial Feb 1 1927

20 UNDERTAKER Chas. N. Johnson ADDRESS 16 N. Gay St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18453

## CERTIFICATE OF DEATH

129 E 18453

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 725 S. Glover St. 1-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas A. W. Hartlove

(a) RESIDENCE NO. 725 S. Glover St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. da. How long in U. S. if of foreign birth? yrs. mos. da.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma A. Hartlove

6 DATE OF BIRTH (month, day, and year): March 5, 1873

7 AGE — Years: 53 — Months: 9 10 — Days: 22 — IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Driver

(b) General nature of industry, business, or establishment in which employed (or employer): 023

(c) Name of employer: City

9 BIRTHPLACE (city or town): Balto

(State or country): Md.

PARENTS

10 NAME OF FATHER: Thomas Hartlove

11 BIRTHPLACE OF FATHER (City or town): Balto

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town): Not Known

(State or country)

14 Informant: Emma A. Hartlove

(Address): 725 S. Glover St

15 Filed: JAN 30 1927 Registrar: HARRISON JONES M D

RH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 27 1927

17 I HEREBY CERTIFY, That I attended deceased from October 2, 1926, to Jan 27, 1927, that I last saw h[im] alive on Jan 27, 1927, and that death occurred, on the date stated above, at 4 50 P. m.

The CAUSE OF DEATH* was as follows:

Chronic interstial nephritis

(duration) Unknown mos. da.

CONTRIBUTORY (Secondary): myocarditis

(duration) years Some mos.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Francis Jamrozik, M. D.

1/28, 1927 (Address) 2426 Fait ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — Date of Burial: Jan. 31, 1927

20 UNDERTAKER: Henry Sander & Sons Inc — ADDRESS: 1710 Fleet St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

E 18454

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

89

E 18454

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 206 S. Broadway St. 3-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Kistler

(a) RESIDENCE NO. 206 S. Broadway St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marie Kistler

6 DATE OF BIRTH (month, day, and year) July 28 1853

| 7 AGE | Years | Months | Days | IF LESS than 1 day ...hrs. or ...min.. |
|---|---|---|---|---|
| | 73 | 6 | 0 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor & Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) 062

(c) Name of employer Broadway Savings Bank

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Jacob Kistler

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Switzerland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Not Known

14 Informant (Mrs) Marie Kistler

(Address) 206 S Broadway

15 Filed JAN 30 1927 By C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 28 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec. 11th, 1926, to Jan. 28th, 1927, that I last saw him alive on Jan. 28, 1927, and that death occurred, on the data stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Syncope

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) 1 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Data of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jacob L Wasman, M. D.

1-29, 1927 (Address) 30 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cemetery — Date of Burial Jan. 31, 1927

20 UNDERTAKER Henry Sander & Sons Inc — ADDRESS 1710 Fleet St

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 18455 — 90 — E 18455

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 1523 Alice Anna St. 3-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Walters

(a) RESIDENCE NO. 1523 Alice Anna St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ernest Walters

6 DATE OF BIRTH (month, day, and year) March 15. 1863

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 63 | 9 10 | 13 12 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Anton Schultz

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Not Known

14 Informant Ernest Walters

(Address) 1523 Alice Anna St

JAN 30 1927 — C. HARRISON JONES, M. D. Registrar

Per PR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 26 1927 to Jan 27 1927

that I last saw her alive on Jan 27 - 1927

and that death occurred, on the date stated above, at 6.30 P. M.

THE CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted — —

If not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? No

What abnormal conditions confirmed diagnosis? Hx Evidence

Signed Wm. H. Gladden M. D.

(Address) 1437 N Gay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: First Evangelical Cemetery — Date of Burial: Jan 30. 1927

20 UNDERTAKER: Henry Sander & Sons Inc — ADDRESS: 1710 Fleet St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18456

## CERTIFICATE OF DEATH.

E 18456

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 709 N Gilmor ST., 16-22 WARD)

2-FULL NAME Louisa Baylor

(a) RESIDENCE NO. Sparks, Balto Co Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | C | Widowed |

5a If married, widowed, or divorced (or) WIFE of Simon Baylor

6 DATE OF BIRTH (month, day, and year) Jan 23 1875

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 52 | | 6 7 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Maid

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer W. S. Pearce Balto Md

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Henry Powell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Lucy Woodell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Lula Mone 709 N Gilmor St Balto Md (Address)

15 FILED JAN 30 1927 E. HAMPTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 22, 1926, to Jan 29, 1927,

that I last saw h alive on Jan 29, 1927, and that death occurred, on the date stated above, at 11 30 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Interstial Nephritis

Hypertension (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R J Young M. D.

1/29/1927 (Address) 1424 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Stephenson Cemetery, Dulaney, Md

DATE OF BURIAL Feb. 1 1927

20 UNDERTAKER Wm C Brooks

ADDRESS Sparks, Md

CAUSE OF DEATH to be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

11 E 18457

E 18457

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 35 W. West St St. 7-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella A. Hayden

(a) RESIDENCE NO. 35 W. West St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Francis J. Hayden

6 DATE OF BIRTH (month, day, and year): Nov. 8, 1860

7 AGE: Years 66 Months 7 Days 20 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Co. Md.

PARENTS

10 NAME OF FATHER: Patrick Cadden

11 BIRTHPLACE OF FATHER (City or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Katherine McLaughlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Francis J. Hayden

(Address): 35 W. West St.

15 Filed JAN 30 1927

C. HAMPSON JONES, M. D. Registrar

Fee

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/28/1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 28, 1926 to Jan 28, 1927.

that I last saw h[er] alive on Jan 27, 1927.

and that death occurred, on the date stated above, at 7:00 a. m.

The CAUSE OF DEATH* was as follows: Cancer of Liver

Loss of appetite for 3 Mos.

(duration) — yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary) Nervous breakdown

(duration) — yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No What test confirmed diagnosis? Clinical

(Signed) J. Patterson M. D.

(Address) 1345 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem. Date of Burial: Jan 31 1927

20 UNDERTAKER: Margaret J. Flynn ADDRESS 14 W. Eight St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

188-003

E 18458

## CERTIFICATE OF DEATH.

E 18458

REGISTERED NO.

1 PLACE OF DEATH Mercy Hospital

City of BALTIMORE: (No. ____ St. 14 Ward) 20

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Hayward Hamilton

(a) RESIDENCE NO. 1421 Mt. Royal Ave. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 13. 1870

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 56 | 3 | 17 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Train Dispatcher

(b) General nature of industry, business, or establishment in which employed (or employer): 073

(c) Name of employer

9 BIRTHPLACE (city or town): Maryland

(State or country)

PARENTS

10 NAME OF FATHER Hugh S. Hamilton

11 BIRTHPLACE OF FATHER (city or town): Md

(State or country)

12 MAIDEN NAME OF MOTHER Margaret Wilbe

13 BIRTHPLACE OF MOTHER (city or town): Md

(State or country)

14 Informant: Margaret V. Hamilton

(Address) 1421 Mt Royal

Filed JAN 30 1927

C. HAMPSON JONES, M. D.
Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 30 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 14 1927, to Jan 30, 1927,

that I last saw h.. alive on Jan 30, 1927

and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Lung Abscess.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 16-1926

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. Jones, M. D.

, 19 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Date of Burial 19

20 UNDERTAKER: John Waterhouse ADDRESS 1900 Eutaw Place

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18459

## CERTIFICATE OF DEATH.

90

E 18459

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1912 Lindew Ave ST. 14-20 WARD)

2-FULL NAME Maria Fossett Mc Gaw

(a) RESIDENCE No. 1912 Lindew Ave ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of): Thomas H. Mc Gaw

6 DATE OF BIRTH (month, day, and year): unknown

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 76 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Frances C Fossett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Delaware

12 MAIDEN NAME OF MOTHER: Orpha Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penna

14 Informant: Grace Fossett
(Address) 1912 Lindew ave

15 Filed JAN 30 1927 C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 29th 1927

17 I HEREBY CERTIFY, That I attended deceased from July 5th, 1922, to Jan 29th, 1927,

that I last saw her alive on Jan 28th, 1927,

and that death occurred, on the date stated above, at 12 20 A.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

Hypertension.

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary): Arter. Sclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Sign & Symptoms

(Signed) J A Rutland M.D.

Jan 29, 1927 (Address) 1300 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount

DATE OF BURIAL: 1927

20 UNDERTAKER: John Whitehead

ADDRESS: 1625 Eutaw St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18460

## CERTIFICATE OF DEATH.

129 E 18460

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 812 E. 41st. ST. 9-47 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Attaway Lewis Morton

(a) RESIDENCE NO. 812 E. 41 St. — ST., ..... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas P. Morton

6 DATE OF BIRTH (month, day, and year): May 22. 1864

7 AGE — Years: 62 — Months: 8 — Days: 7 — If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home duties

(b) General nature of industry, business, or establishment in which employed (or employer): 27

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: John Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Eliz. Stuart

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Staunton Va.

14 Informant: Elsie Goldsmith
(Address) 812 E. 41st St.

HAMPSON JONES, M. D.
Registrar

JAN 30 1927

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1-29-1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 18 .1927. to Jan 29 .1927.

that I last saw her alive on Jan 28 .1927.

and that death occurred, on the date stated above, at 12.45 A. m.

The CAUSE OF DEATH* was as follows:

Chron Interstitial Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) ..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. W. Hoces, M. D.

1-29 1927 (Address) 5600 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fleders Funeral

DATE OF BURIAL: Jan 31 1927

UNDERTAKER

ADDRESS 1730 Pennsylvania Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

Samuel Rapport

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18461

CERTIFICATE OF DEATH.

× 129

E 18461

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. ~~Lanvale Apts~~ Sinai Hospital St. 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Rapport.

(a) RESIDENCE NO. Durham N. C St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Dora Rapport

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE: Years 55 | Months — | Days — | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ~~Tobacco Dealer~~ Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Russia

(State or country)

PARENTS

10 NAME OF FATHER: Oscar Rapport

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Russia

12 MAIDEN NAME OF MOTHER: Antonn

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Russia

14 Informant: S. A. Blumberg

(Address): Durham N. C

15 Filed JAN 30 1927

HARRISON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

1-30-27

17 I HEREBY CERTIFY, That I attended deceased from Jan 17, 1927, to Jan 30, 1927, that I last saw h[im] alive on Jan 30, 1927, and that death occurred, on the date stated above, at 6.30 a.m.

The CAUSE OF DEATH* was as follows:

~~Chronic nephritis~~

~~Hypertension~~

Uremia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic nephritis

Hypertension

(duration) yrs. 2 mos. 7 ds.

18 Where was disease contracted if not at place of death? Durham N. C

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) Mad Rappaport, M. D.

1/30, 1927 (Address) Sinai Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Durham N. C Date of Burial 1/30 1927

20 UNDERTAKER: Jack Lewis ADDRESS 1439 Eutaw St ×

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18462

## CERTIFICATE OF DEATH.

129

E 18462

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Tudor Hall Apts. ST. 12-49 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mai. Ahler Ulrich

(a) RESIDENCE No. Tudor Hall Apts ST., WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William L Ulrich

6 DATE OF BIRTH (month, day, and year) Nov-12-1875

| 7 AGE Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|
| 51 | 2 | 16 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Alexandria Virginia

PARENTS

10 NAME OF FATHER Lycurgus E. Ahler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Alexandria Virginia

12 MAIDEN NAME OF MOTHER Alice Hough

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Alexandria Virginia

14 Informant Mrs. L. Ulrich (Husband) (Address) Tudor Hall apts City

15 Filed JAN 30 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 28 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec-1 1925 to Jan 28 1927, that I last saw h[illegible] alive on Jan. 28 1927, and that death occurred, on the date stated above, at 12-15A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage at Base of Brain due to General arteriosclerosis.

(duration) yrs 1 hour mos ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis

Chronic (duration) 1 yrs. 2+ mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Was found unconscious 2 or 3 minutes after awaking, died in 2 few minutes after awaking.

M. Virgil Porter, M. D.

1/28, 1927 (Address) 422 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dulaney Towers City. DATE OF BURIAL Jan 31 1927.

20 UNDERTAKER STEWART & HOWEN COMPANY (Successor to Howen & Stewart) ADDRESS 108 W. NORTH AVE.

CAUSE OF DEATH must be filled in plainly, and must be signed. See instructions on back of certificates. TION is very important.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

100-001

E 18463

E 18463

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No._____ St., 18-29 Ward

2-FULL NAME Olivia Moore

(a) RESIDENCE NO. 16 S. Stockton St._____ Ward_____

(Usual place of abode) ?

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Colored | ? |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1852

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 74 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Isaac Moore

11 BIRTHPLACE OF FATHER (city or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant BALTIMORE CITY HOSPITALS

(Address) C. H. Records

C. HAMILTON JONES, M. D.

15 Filed JAN 30 1927 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 27 1927

17

I HEREBY CERTIFY, That I attended deceased from October 25, 1926, to January 27, 1927, that I last saw h[illegible] alive on January 27, 1927, and that death occurred, on the date stated above, at 10.30 P m.

The CAUSE OF DEATH* was as follows:

Senility

Cerebral Sclerosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? General & Laboratory

(Signed) C. H. Cooper Smith, M. D.

Jan 29. 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery Date of Burial 1/31/1927

20 UNDERTAKER Wm. Geo. H. Holland ADDRESS 1631 Druid Hill Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18464

## CERTIFICATE OF DEATH

101-001

REGISTERED NO. E 18464

1-PLACE OF DEATH

City of BALTIMORE: (No. 117 E. Hamburg St. 23-33 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace L. Trezise

(a) RESIDENCE NO. 117 E. Hamburg St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Francis E. Trezise Jr.

6 DATE OF BIRTH (month, day, and year) July 7, 1880

| 7 AGE | Years | Months | Days |
|---|---|---|---|
| | 46 | 6 | 21 |

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particolar kind of work Housewife

(b) General nature of Indostry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Phila., Pa.

(State or country)

PARENTS

10 NAME OF FATHER Wm. Johnson

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Phila., Pa.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Francis E. Trezise Jr.

(Address) 117 E. Hamburg St

JAN 30 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Jany 28, 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept, 1927, to Jany 28, 1927,

that I last saw h[illegible] alive on Jany 27, 1927,

and that death occurred, on the date stated above, at 11.55 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Gastritis

(duration) yrs. 4½ mos. ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) O. C. Smith, M. D.

19 (Address) Jany 29/27. 19 W. Lee St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — Date of Burial Feb. 1 1927

20 UNDERTAKER Margaret A. Flynn — ADDRESS 1422 Light

THE BURDEN OF CERTIFYING SUFFICIENT FACTS TO IDENTIFY THE DECEASED, AND TO DETERMINE THE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18465

## CERTIFICATE OF DEATH.

188-002 E 18465

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH University Hospital

City of BALTIMORE: (No. Lombard & Greene Sts. 4th 25 Ward)

2-FULL NAME Maria Wharton

(a) RESIDENCE NO. 627 Redwood St. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George D. Wharton

6 DATE OF BIRTH (month, day, and year) Unknown 1857

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 70 | xxx | xxx | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Prince Georges County Md.

PARENTS

10 NAME OF FATHER Thomas Hodgkin

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant (Address) Mr. Blake Bourne 738 W. North Avenue

Filed JAN 30 1927, 19 H. JONES M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 28 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock following accidental fracture of left femur

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) Wm. H. Drake M. D.

(Coroner)

Jan 29 1927 (Address) 332 S. Patterson Pk. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery Date of Burial Jan. 31 1927

20 UNDERTAKER Joseph H. Cook ADDRESS 1003 W. Pratt

Be sure the following supplies, and that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

Robert V. Brown

E18466 HEALTH DEPARTMENT—CITY OF BALTIMORE 1/31 18466

E 18466

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hospital (St.) 1-48 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert V. Brown

(a) RESIDENCE NO. 415 Homeland Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) — 1893

| 7 AGE | Years | Months | Days | If LESS than 1 day, brs. or min. |
|---|---|---|---|---|
| | 33 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fruit - Dealer

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Mich Brown

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Hatter

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Jos Brown

(Address) 415 Homeland Ave

Filed JAN 31 1927 C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan-29-1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 20, 1927, to Jan 29, 1927, that I last saw him alive on Jan 29, 1927, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Paralytic Ileus

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Pyonephrosis

(duration) yrs. 2 mos. 10 ds.

18 Where was disease contracted if not at place of death? Tampa Florida -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical -

(Signed) Frank R. DeDavila, M. D.

, 19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary's Cemetery DATE OF BURIAL 1/31 1927

20 UNDERTAKER J. J. Fahey & Son ADDRESS 131 Eight St

TION is very important See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

2318 Harlem Ave

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 18467 — PLACE OF DEATH

REGISTERED NO. 49 E 18467

City of BALTIMORE: (No. 5107 Belleville ave St.) (Ward 26 Howard Park 4)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Lawrence Leipp

(a) RESIDENCE NO. 5107 Belleville ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred? life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M. | W. | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dorthy C. Leipp

6 DATE OF BIRTH (month, day, and year) Sept 16th 1900

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 26 | 4 | 11 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer E. N. Katz.

9 BIRTHPLACE (city or town)

(State or country) Balto City.

PARENTS

10 NAME OF FATHER Lawrence V. Leipp

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Della Schwab

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto City.

14 Informant Dorthy C. Leipp.

(Address) 5107 Belleville Ave

Filed JAN 31 1927 E. HAMILTON JONES M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 18 1926, to Jan 27, 1927, that I last saw h— alive on Jan 28, 1927, and that death occurred, on the date stated above, at 7 40 m.

The CAUSE OF DEATH* was as follows:

Malignant Neoplasm of rectum.

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Carcinomatosis Abdomen

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of 1/19/27 - 1/24/27

Was there an autopsy? No

What test confirmed diagnosis? Path.

(Signed) Edw Emerson, M. D.

Jan 29, 1927 (Address) 5107 Belleville Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery Date of Burial 1/31 1927

20 UNDERTAKER Patrick F. Casey ADDRESS 2425 Ellicott Driveway.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18468

## CERTIFICATE OF DEATH.

129 E 18468

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Josephs Hospital

CITY OF BALTIMORE: (No. Caroline & Oliver ST. 12-51 WARD)

2-FULL NAME Susie Galt.

(a) RESIDENCE NO. 419 W. 28th ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | white | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) unknown.

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 71 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Mollie Hull (Address) Westminster Md.

15 Filed JAN 31 1927 C. HAMPSON JONES, M. D. Registrar

By —

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1927, to Jan 30, 1927, that I last saw her alive on Jan 30, 1927, and that death occurred, on the date stated above, at 6:05 p. m.

The CAUSE OF DEATH* was as follows:

Chr. Nefritis. Hypertension
Acute Glaucoma

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral. Hemmbage.

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical.

(Signed) Clement R. Worrall, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Prince Grove Cem. Westminster

DATE OF BURIAL Feb 2 1927

20 UNDERTAKER H. Bankard Westminster Md.

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

# E 18469

## CERTIFICATE OF DEATH.

129

E 18469

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1413 Annapolis Ave., West 25 Ward) 32 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Zackman

(a) RESIDENCE NO. 1413 Annapolis Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Ma.

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah E.

6 DATE OF BIRTH (month, day, and year): Aug. 18. 56.

7 AGE — Years: 72 | Months: 5 | Days: 10 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): 015

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Germa.

PARENTS

10 NAME OF FATHER: Henry Zackman.

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Germany.

12 MAIDEN NAME OF MOTHER: unknown.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: Sarah E. Zackman

(Address): 1413 Annapolis Ave

15 Filed ....., 19..... C. HARRISON JONES, M. D. Registrar

JAN 31 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): January 28. 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1926, to Jan. 28, 1927, that I last saw h.. alive on January 27, 1927, and that death occurred, on the date stated above, at 8:30A m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 2? yrs. mos. ds.

CONTRIBUTORY (Secondary): Nephritis chronic interstitial

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical sign

(Signed) M. Hamm, M. D.

1/28. 1927 (Address) 1822 W Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — Date of Burial: Jan 31 1927

20 UNDERTAKER: Hy Stiles — ADDRESS: 1200 N Lombard

Don should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should take CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 18470

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

7-1001

E 18470

REGISTERED NO.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. ____ St., 19-28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Lidell

(a) RESIDENCE NO. 324 South Calhoun St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | White | ? |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1851

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 76 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ?

(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?

(State or country)

14 Informant (Address) Records

15 Filed JAN 31 1927 H. MARTIN BOYD, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 29 1927

17 I HEREBY CERTIFY, That I attended deceased from January 18, 1927, to January 29, 1927, that I last saw him alive on January 29, 1927, and that death occurred, on the date stated above, at 7.20 p m.

The CAUSE OF DEATH* was as follows:

Senility

Residual left Hemiplegia Thrombosis (duration) 2 yrs. ____ mos. 2 ds.

CONTRIBUTORY Cerebral Hemorrhage (Secondary) (duration) ____ yrs. ____ mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? general & laboratory

(Signed) E. Cooper Leavitt, M. D.

Jan 30 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Date of Burial 2/1 1927

20 UNDERTAKER John J. Fields ADDRESS 1200 W Lombard

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE.

E 18471

## CERTIFICATE OF DEATH.

E 18471

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1100 W Lombard ST. 18-29 WARD)

2-FULL NAME Jarrett Trust

(a) RESIDENCE NO. 1100 W Lombard ST., ..... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 18 1926.

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | | 2 | 12 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Jarrett Trust

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Emelia Schmidt

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Germany

14 Informant Jarrett Trust
(Address) 1100 W Lombard

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 21, 1927 to Jan 30, 1927.

that I last saw him alive on Jan 29, 1927.

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) ..... yrs. ..... mos 1 1 ds.

CONTRIBUTORY
(Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Typical Symptoms

(Signed) [illegible] M. D.

Jan 30 1927 (Address) 54 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Jan 31 1927

20 UNDERTAKER John J Fields

ADDRESS 1200 W Lombard

JAN 31 1927. HAMILTON JONES, M. D. Registrar.

Per .....

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

## CERTIFICATE OF DEATH.

E 18472 — 1-PLACE OF DEATH — REGISTERED NO. E 18472

CITY OF BALTIMORE: (No.) 515 Nunsen ST., 17-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert G. Ditto

(a) RESIDENCE NO. 515 Nunsen ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of ~~foreign birth?~~ yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male. 4 COLOR OR RACE: Colored 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ida. Ditto

6 DATE OF BIRTH (month, day, and year): 1866

7 AGE: 60 — Years: 61 Months: Days: If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Day Laborer for Plumber

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. md

PARENTS

10 NAME OF FATHER: Chas. G. Ditto

11 BIRTHPLACE OF FATHER (city or town) (State or country): md

12 MAIDEN NAME OF MOTHER: Sarah Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): md

14 Informant: Ida Ditto (Address): 515 Nunsen St

15 Filed JAN 31 1927 C. HAMPSON JONES, M. D. Registrar

For

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 28th 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1— 1927 to Jan 28th 1927.

that I last saw him alive on Jan 27— 1927.

and that death occurred, on the date stated above, at 12:30 a. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary): Acute Bronchitis

(duration) yrs. mos. 28 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Samuel A Bani, M. D.

, 19 (Address) 937 Modena Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: Jan 31, 1927

20 UNDERTAKER: John H. Frederick — ADDRESS: 1021 Lend Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18473

E 18473

## CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 648 W. Lee St. 22-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Garnell Harris

(a) Residence No. 648 W. Lee St. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 3-10-1926

7-AGE, ..... yrs. 10 mos. 9 ds. 18 29

If LESS than 1 day, .... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer)..... None

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Newport News Va

PARENTS.

10-NAME OF FATHER, Wm Hope

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Va

12-MAIDEN NAME OF MOTHER, Victoria Harris

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), N. C.

14- (Informant) Victoria Harris

(Address) 645 W. Lee St

15- Filed JAN 31 1927 C. HAMPSON JONES, M. D. Registrar. By [illegible]

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 1-29-27

17- I HEREBY CERTIFY, That I attended deceased from 1-28 ....., 1927, to 1-29 ....., 1927, that I last saw h.. alive on Jan 29th ....., 1927, and that death occurred, on the date stated above, at 1 A.M. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

..... (Duration) ? yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ?

..... (Duration) ? yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) W. A. Crook M. D.

, 19 (Address) 617 W. Lee St (Same Building Exit Cross)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Calvary — DATE OF BURIAL, Jan 31, 1927

20-UNDERTAKER. John H. Scudieri — ADDRESS 1027 Hanover

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

E 18474

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18474

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. 27-48

City of BALTIMORE: (No. 900 Beaumont Ave. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary J. Parks

(a) RESIDENCE NO. 900 Beaumont Ave. Ward Cambridge

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 0 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George C. Parks.

6 DATE OF BIRTH (month, day, and year): Dec 23, 1860

7 AGE: Years 66 Months 1 Days 7 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 637

(c) Name of employer

9 BIRTHPLACE (city or town) Dorchester Co. (State or country)

PARENTS

10 NAME OF FATHER Wm. H. Mukins

11 BIRTHPLACE OF FATHER (City or town) (State or country) Dorchester Co.

12 MAIDEN NAME OF MOTHER Martha Mukins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dorchester Co.

14 Informant H. G. Parks + Clarence Parks (Address) 900 Beaumont Ave.

C. HAMPSON JONES, M. D.

15 Filed ..... 19 ..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927. Jan 30

17 I HEREBY CERTIFY, That I attended deceased from Jan 16, 1927, to Jan 30, 1927, that I last saw h[er] alive on Jan 29, 1927, and that death occurred, on the date stated above, at 7.45 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Peritoneum + Abdominal Glands and of Left Jaw.

(duration) 1 yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary) Insanity + Intoxication

(duration) ..... yrs. 6+ mos. ..... da.

18 Where was disease contracted Dorchester Co.

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) D. K. Bishop M. D.

Jan 31, 1927 (Address) 501 Glenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cambridge Md — Date of Burial: Jan 31 1927

20 UNDERTAKER: Ehenowitz Son — ADDRESS: 367 Christmas

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

# E 18475 HEALTH DEPARTMENT—CITY OF BALTIMORE E 18475

## CERTIFICATE OF DEATH.

52

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 205 Roland Ave. (ST.) (WARD) 27-53

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia E. Jones

(a) RESIDENCE NO. 205 Roland Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of T. Milton Jones

6 DATE OF BIRTH (month, day, and year) October, 9th 1868

| 7 AGE Years | Months | Days | If LESS than 1 day, hrs or min |
|---|---|---|---|
| 58 | 3 | 21 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

037

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER M. Pfeifer

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Katherine Yaeger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant T. Milton Jones

(Address) 205 Roland Ave.

15 Filed JAN 31 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January, 30th 1927

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1923, to Jan 30/27, 19, that I last saw him alive on Jan 30/27, 19, and that death occurred, on the date stated above, at 1.05 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 3½ yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible] M. D.

Jan 30/27 (Address) 1 W Eager

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Pk

DATE OF BURIAL Febr 1 1927

20 UNDERTAKER Joseph B Cook

ADDRESS 1008 W Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Please read carefully. TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18476

## CERTIFICATE OF DEATH.

118-001

E 18476

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospital St. 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Dodenich

(a) RESIDENCE NO. 2018 Ellsworth St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mazie Dodenich

6 DATE OF BIRTH (month, day, and year) Dec 12-1877

7 AGE: Years 49 | Months 1 | Days 17 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Broiler

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER Frank Dodenich

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Sphie

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Hospital records

(Address)

15 Filed ..... 19 ..... C. HARRY JONES M. D. Registrar

Per .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 29. 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Jan 26. 1927 to Jan. 29. 1927

that I last saw him alive on Jan 29. 1927

and that death occurred, on the date stated above, at 10 9 m.

The CAUSE OF DEATH* was as follows:

Strangulated Hernia

Left Inguinal

(duration) yrs. mos. 1½ ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of Jan. 26. 1927

Was there an autopsy? no

What test confirmed diagnosis? Typical Signs & Symptoms

(Signed) H. Blumenthal M. D.

, 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — Date of Burial: Feb 1 1927

20 UNDERTAKER: Zickler & Zickler — ADDRESS: 1739 E Eager St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

ANS FEB 1927

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18477

## CERTIFICATE OF DEATH.

90 E 18477

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 805 S. Streeper ST. 1-1 WARD)

2-FULL NAME Emma L. Stahm

(a) RESIDENCE NO. 805 S. Streeper ST., ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles H. Stahm

6 DATE OF BIRTH (month, day, and year) May 6 1861

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 65 | 8 | 20 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work) At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William Turner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Caroline Snyder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto., Md.

14 Informant Charles H. Stahm

(Address) 805 S. Streeper St

JAN 31 1927 HAMPSON JONES, M. D.

Registrar

Per .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 28 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1922, to Jan 4, 1927, that I last saw h-r alive on Jan - 25, 1927 and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 7 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. J. Davidow, M. D.

, 19 (Address) 3035 Odonnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery

DATE OF BURIAL Feb 1 1927

20 UNDERTAKER Zirkler & Zirkler

ADDRESS 1739 E. Eager

Spec.–7-17-26—A Co.—200 Bks.

18478

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

74-001

E 18478

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1217 Ashland Ave St., 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank J. Hallameyer

(a) RESIDENCE NO. 1217 Ashland Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 66 yrs. 3 mos. 7 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie M. Hallameyer

6 DATE OF BIRTH (month, day, and year) October 22 1860

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min.. |
|---|---|---|---|---|
| | 66 | 3 | 7 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shipping Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) 069

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER John Hallameyer

11 BIRTHPLACE OF FATHER (City or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Falter.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Annie M. Hallameyer (Address) 1217 Ashland Ave

15 Filed JAN 31 1927, 19 C. HARRISON JONES, M. D. Registrar

By R H

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 29. 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 24, 1927, to Jan 29, 1927.

that I last saw him alive on Jan 29, 1927.

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY Arteriosclerosis (Secondary)

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robert F. Green, M. D.

1-30, 1927 (Address) 120 Augusta St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — Date of Burial Feb. 1 1927

20 UNDERTAKER Henry Hoerdt Son — ADDRESS 1301 E Eager St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18479

## CERTIFICATE OF DEATH.

E 18479

1-PLACE OF DEATH

City of BALTIMORE: (No. Lakeland, Balto. Md St. 25-73 Ward) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gordon J. Rogers

(a) RESIDENCE NO. #1 Belvidere Pl. - Lakeland St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mns. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 2X 1915

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 11 | 7 | 3 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country)

PARENTS

10 NAME OF FATHER John N. Rogers

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country)

12 MAIDEN NAME OF MOTHER Martha V. Dixon

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant John N. Rogers.

(Address) Lakeland Balto.

Filed JAN 31 1927 C. HARRISON JONES, M. D.

By Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29 1927

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquest (Inquest or Autopsy or Inquiry) thereon and from the evidence obtained [illegible] Inquiry and had that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Walking on ice on a pond & ice broke

(duration) yrs. mos. ds.

(Signed) Thos. B. Norton M. D.

(Coroner)

Jan 29 1927 (Address) Curtis Bay, Balto, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rogers Graylied-at Leisure

Date of Burial Feby 1st 27

UNDERTAKER Gaynor & Son

ADDRESS 901 W. Fayette St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

Wilson

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18480

## CERTIFICATE OF DEATH

129

E 18480

1-PLACE OF DEATH

City of BALTIMORE: (No. Provident Hosp St. 10-14 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Wilson

(a) RESIDENCE NO. 1218 E Monument St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1874

7 AGE: Years 53 Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) Md. (State or country)

PARENTS

10 NAME OF FATHER Henry Bell

11 BIRTHPLACE OF FATHER (City or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Maranda Johnson

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Mary E. Morris

(Address) 1107 Bolton st

Filed JAN 31 1927 H. HARRISON JONES, M. D. Registrar

By RM

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 21 1927 to Jan 29 1927

that I last saw h alive on " " 1927

and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Chronic Nephritis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis ?

(duratinn) ? yrs. mns. ds.

18 Where was disease contracted ?

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Clinical

(Signed) J. W. Lane M. D.

. 19 (Address) Provident Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel cemetery Date of Burial Feb 1 1927

20 UNDERTAKER: Edward Bryan ADDRESS 1681 Orleans St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18481

## CERTIFICATE OF DEATH.

101-001

E 18481

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 508 S Bond st. (ST.) 3-4 (WARD)

2-FULL NAME Teresa Olszewska.

(a) RESIDENCE NO. 508 S. Bond st. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 31 1925

7 AGE: Years 1 Months 3 Days 30 29 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant. 8d

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore md.

PARENTS

10 NAME OF FATHER: Stanislaw Olszewski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland.

12 MAIDEN NAME OF MOTHER: Bronislawa Jagwick

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland.

14 Informant (Address): Stanislaw Olszewski 508 S Bond st

15 Filed ..... 19 .....

By ..... Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 30 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 23, 1927, to Jan 30, 1927, that I last saw h[illegible] alive on Jan 30, 1927, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Cardiac Foreclosure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. Reynolds M. D.

Jan 31 1927 (Address) 801 N Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Cem. DATE OF BURIAL: Feb 1 1927

20 UNDERTAKER: George A Weber ADDRESS: 2205 Bank st

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JAN 7 1927 (illegible)

Cor.—1-12-23—M&T—100 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18482

## CERTIFICATE OF DEATH.

E 18482

1-PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE (No.) Hippodrome St. Infirmary WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Thomas Richards

(a) RESIDENCE No. 423 Chatterton ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| M | W | Widowed |

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Anna B. Richards

6 DATE OF BIRTH (month, day, and year) Feb 20 1861

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 65 | 11 | 7 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) 015
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Robt. F. Richards

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Julia Montgomery

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Ella Richards
(Address) 423 Chatterton ave

15 Filed JAN 31 1927, 192 C. HARPER JONES, M. D. Registrar
By

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/27 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:
Congestion Pulmonary

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) Samuel A Decker, M. D.
(Coroner.)
, 192 (Address) 1325 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL
Loudon Park 1/31 1927

20 UNDERTAKER J. A. Moran — ADDRESS 30 E. Baltimore

TION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

90 E 18483

REGISTERED NO.

E 18483

1-PLACE OF DEATH

City of BALTIMORE: (No. 3 S. Collington Ave St. 1-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John King

(a) RESIDENCE NO. 3 S. Collington Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth King

6 DATE OF BIRTH (month, day, and year) May 27-1847

7 AGE Years 79 Months 8 Days IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work U.S. Govt Inspector

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer 086

9 BIRTHPLACE (city or town) ...

(State or country) Scotland

PARENTS

10 NAME OF FATHER dont know

11 BIRTHPLACE OF FATHER (City or town) ...

(State or country) Scotland

12 MAIDEN NAME OF MOTHER dont know

13 BIRTHPLACE OF MOTHER (city or town) ...

(State or country) "

14 Informant Charles King

(Address) 3 S. Collington Ave

Filed JAN 31 1927 C. Hunter Jones M.D. Registrar

By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 27 19 27

17 I HEREBY CERTIFY, That I attended deceased from January 20, 19 27, to January 27, 19 27,

that I last saw him alive on January 27, 19 27,

and that death occurred, on the date stated above, at 4-15 P. M.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) ... yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation

(duration) ... yrs. mos. 7 ds.

18 Where was disease contracted

If not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) Isabel V. Fahey M. D.

Jan 29 1927 (Address) 100 S. Patterson Park Balto

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem.

Date of Burial 1/31 1927

20 UNDERTAKER J. A. Moran

ADDRESS 300 E Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

E 18484

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

## CERTIFICATE OF DEATH

16-22

E 18484

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1717 Riffs ave St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maryella Redd

(a) RESIDENCE NO. 1747 Riffs ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | Colored | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 1 1918

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min.. |
|---|---|---|---|---|
| | 8 | 5 | 27 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) Prince George co.

(State or country) Va

PARENTS

10 NAME OF FATHER Wesley Redd

11 BIRTHPLACE OF FATHER (City or town) Prince George co

(State or country) Va

12 MAIDEN NAME OF MOTHER Gertrude Redd

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Prince George co Va

14 Informant Father

(Address) 1717 Riffs ave

Filed JAN 31 1927, 19 C. HARRISON JONES, M. D. Registrar

Per R H

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-28-1927

17 I HEREBY CERTIFY, That I attended deceased from 1-22-, 1927, to 1-28-, 1927.

that I last saw h[illegible] alive on 1-28-, 1927.

and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Septic Tonsilitis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Dr. R. T. Saunders, M. D.

. 19 (Address) 1029 N Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Mt Auburn cem | Jan 31 1927 |
| 20 UNDERTAKER Daniel Carter | ADDRESS 916 Baltimore |

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

La Rugina 500 Fall Mt Ave

11-001

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 18485

REGISTERED NO. E 18485

1-PLACE OF DEATH

City of BALTIMORE: (No. 125 N. Kenwood Ave St., 6-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy E. Fuller

(a) RESIDENCE NO. 125 N. Kenwood Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| F | W | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 11, 1927

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min.. |
|---|---|---|---|---|
| | | | 18 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md

PARENTS

10 NAME OF FATHER Vernon C Fuller

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Brigitte A Young.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Vernon C Fuller

(Address) 125 N Kenwood Ave

15 Filed JAN 31 1927 19 C. HARRY JONES, Registrar

By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 11 27 to Jan 29 27, 19 27, that I last saw h alive on Jan 29 27, 19 27 and that death occurred, on the data stated above, at 6:05 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

Lafayette

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos 2 ds.

18 Where was disease contracted

If not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) Fred Rupprecht M. D.

1927 (Address) 500 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel

Date of Burial Jan 31 1927

20 UNDERTAKER H. H. Cook

ADDRESS 502 E Lexington

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

113 E 18486

## CERTIFICATE OF DEATH.

E 18486

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 2667 Frederick Av 90-69 St., ____ Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Melvin C. T. Heward

(a) RESIDENCE NO. 25 Hafer St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 9 1926

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | — | 1 | 21 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md

(State or country)

PARENTS

10 NAME OF FATHER Rudolph T. Heward

11 BIRTHPLACE OF FATHER (city or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Mary C. Lang

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country)

14 Informant Mary C. Heward

(Address) 25 Hafer St

Filed JAN 31 1927, H. HARRISON JONES, M. D. Registrar

By _____

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intestinal Indigestion

(duration) — yrs. — mos. 3 hours

CONTRIBUTORY (Secondary) ____ (duration) ___ yrs. ___ mos. ___ ds.

(Signed) Thos. B. Norton M. D.

(Coroner)

Jan 30 1927 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional items.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ___ yrs., ___ mos., ___ ds. In the State ___ yrs., ___ mos., ___ ds.

Where was disease contracted, if not at place of death? ____

Former or usual residence ____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cemetery Date of Burial Feb 1 1927

20 UNDERTAKER H. Lander Sons ADDRESS 176 Park Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—This certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

Notaro

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-004

E 18487 E 18437

## CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1012 E Pratt St 3-5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary Notaro

(a) RESIDENCE NO. 1012 E. Pratt. St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nick Notaro

6 DATE OF BIRTH (month, day, and year) January 27. 1902.

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min.. |
|---|---|---|---|---|
| | 25 yrs. | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work [illegible]

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Lizzy

(State or country) Italy

PARENTS

10 NAME OF FATHER Frank Lavrghetta

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Italy

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Italy

14 Informant Jack Notaro

(Address) 1012 E Pratt St

Filed JAN 31 1927 C. HARRY JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29th 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 24, 1927 to Jan 29, 1927

that I last saw her alive on Jan 29, 1927

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Cardio-respiratory insufficiency

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Pneumonia, lobar, right side (duration) yrs. 1 mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Tests

(Signed) Atheron Hunter, M. D.

1/29. 1927 (Address) St. Agnes' Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

Date of Burial 2/1 1927

20 UNDERTAKER Kendel & Appel

ADDRESS 300 [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

Keil

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 18488

## CERTIFICATE OF DEATH.

E 18488

REGISTERED NO. _____

1-PLACE OF DEATH

City of BALTIMORE: (No. 2554 W. Balto St. 20-69 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Garry Keil

(a) RESIDENCE NO. 2554 W. Balto St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. 2 mos 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Alice L. Keil

6 DATE OF BIRTH (month, day, and year) Nov 8. 1873

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 53 | 2 | 19 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Inspector Weights & Measures 086

(b) General nature of Industry, business, or establishment in which employed (or employer) Inspecting Weights & Measures 086

(c) Name of employer Balto City

9 BIRTHPLACE (city or town) _____

(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Frederick Keil

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Elizabeth Burger

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Balto. Md.

14 Informant Alice L. Keil

(Address) 2554 W. Balto St.

15 Filed JAN 31 1927 C. HARRISON JONES, M. D.

By _____ Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 Jan 27. 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 22, 1927, to Jan 27, 1927, that I last saw him alive on Jan 27, 1927, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) 6 yrs. 6 mos. 6 ds.

CONTRIBUTORY (Secondary) None

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted _____

If not at place of death? _____

Did an operation precede death? No Date of _____

Was there an autopsy? No What test confirmed diagnosis? Clinical test

(Signed) Henry C Ohla, M. D.

Jan 31 1927 (Address) 1203 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Loudon Park Date of Burial Jan 31 1927

20 UNDERTAKER George J Smith ADDRESS 1532 Hollins

S. R.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 18489

E 18489

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 109 S. Sixth St., Brooklyn Ward 20

2-FULL NAME Thomas C. Foreman

(a) RESIDENCE No. 109 S. Sixth St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widowed |

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine C. Foreman

6 DATE OF BIRTH (month, day, and year) Oct 1847

| 7 AGE Years | Months | Days | If LESS than 1 day, ....hrs or ....min. |
|---|---|---|---|
| 79 | 3 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) Magothy (State or country) Md

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) Don't Know (State or country)

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) Don't Know (State or country)

14 Informant Mrs W. C. Meyers (Address) 109 S. 6th St Brooklyn Md

15 Filed JAN 31 1927 HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 28 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 27, 1926, to Jan 28, 1927, that I last saw him alive on Jan 27, 1927, and that death occurred, on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows: Chronic interstitial nephritis

(duration) unknown

CONTRIBUTORY (Secondary) Cardio vascular disease

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Lab

(Signed) Wm E Sutton, M. D.

1/29, 1927 (Address) 1319 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet DATE OF BURIAL Jan 31 1927

20 UNDERTAKER John F Denny ADDRESS 715 Light St

mation should be carefully supplied. AGE should be stated EXACTLY. Illegible or incomplete certificates.
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

**E 18490** — **CERTIFICATE OF DEATH.** — **E 18490**

REGISTERED NO. 20-72

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Abraham Schloffman

(a) RESIDENCE NO. 2141 Eagle St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? 16 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 Color or Race: white | 5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Tillie Schloffman

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE: Years 35 | Months — | Days — | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Tailor
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town):
(State or country) Russia

PARENTS

10 NAME OF FATHER: Lipey Schloffman

11 BIRTHPLACE OF FATHER (city or town):
(State or country) Russia

12 MAIDEN NAME OF MOTHER: Antsen

13 BIRTHPLACE OF MOTHER (city or town):
(State or country) Russia

14 Informant: Tillie Schloffman
(Address) 2141 Eagle St

Filed JAN 31 1927 C. HAMPSON JONES, M. D., Registrar
Per R.P.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/30/ 1927

17 I HEREBY CERTIFY, That I attended deceased from 11/23/ 1927 to 11/30/ 1927,
that I last saw h.. alive on 11/30/ 1927,
and that death occurred, on the date stated above, at 12.30 m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of no
Was there an autopsy? — no —
What test confirmed diagnosis? X-Ray

(Signed) John A. Warfield, M. D.
1/30. 1927 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Workmen circle Cem — Date of Burial 1/31 1927

20 UNDERTAKER: Jack Levis — ADDRESS 1496 E Balto

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18491

118-002

## CERTIFICATE OF DEATH.

E 18491

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 26-37 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Hyman Heller

(a) RESIDENCE NO. 4331 Lombard (E) St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? 34 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Lena Heller

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 71 | Months — | Days — | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Russia

14 Informant Mrs. Fannie Bamberger

(Address) 4331 E. Lombard St

Filed JAN 31 1927 C. HAMPTON JONES, M. D. Registrar

Per R. R.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/31/1927

17 I HEREBY CERTIFY, That I attended deceased from 1/29/1927, to 1/31/1927, that I last saw h[illegible] alive on 1/31/1927, and that death occurred, on the date stated above, at 9.30a. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Cannot be ascertained.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John A Aspin, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale — Date of Burial 1/31 1927

20 UNDERTAKER: Jack Levin — ADDRESS 1434 E Baltd St

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD. Any item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 18492 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 E 18492

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1732 Warwick ave ST. 15-68 WARD)

2-FULL NAME Rachel Kantor

(a) RESIDENCE No. 1732 Warwick ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? 24 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | W | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of David Kantor

6 DATE OF BIRTH (month, day, and year) unknown

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 57 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Louis Berkowitz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Perel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Sara Kantor

(Address) 1732 Warwick ave

Filed JAN 31 1927 By RC Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/30 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1 1926 to Jan 30 1927, that I last saw h[illegible] alive on Jan 30 1927 and that death occurred, on the date stated above, at 8 [illegible] m

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency, Arteriosclerosis, Chronic Interstitial Nephritis, Diabetes Mellitus, Uremic and Diabetic Coma (duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Cardiac and Respiratory failure (duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? Parenchymatous Nephritis, Chronic Interstitial

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam. of Bloods

(Signed) Louis N. Epstein, M. D.

1/31 1927 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Herman Rans DATE OF BURIAL 1/31 1927

20 UNDERTAKER Jack Lewis ADDRESS 1439 E. Baltimore St.

C. HARRISON [illegible], M. D.

mation should be carefully supplied. AGE should be stated [illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 18493

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 18493

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 57 Main St Hilldale WARD 28-b-t

2-FULL NAME Martha Whitmore

(a) RESIDENCE NO. 107 Main St Hilldale Balto Md WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | W | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joshua Whitmore

6 DATE OF BIRTH (month, day, and year) Nov 20 44

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 82 | 2 | 9 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Work

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Gibson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Statum

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant John Whitmore

(Address) Main St Hilldale Md.

15 Filed JAN 31 1927. 19

C. HAMPSON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29th 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 23, 1926, to Jan 27, 1927,

that I last saw h[illegible] alive on Jan 27, 1927

and that death occurred, on the date stated above, at 7. A m

The CAUSE OF DEATH* was as follows:

Senile Bronchitis.

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Valvular Heart Trouble (duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo Eberhart M. D.

1/28 1927 (Address) Woodlawn Md Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid cemetery

DATE OF BURIAL Jan 31 1927

20 UNDERTAKER H M Courtenay

ADDRESS 2258 12 Balto

mation should be carefully supplied. AGE should be stated EXACTLY in years, months and days. Exact statement of OCCUPATION is very important See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-12-23—M&T—500 Blks.

Emma Walters

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18494

## CERTIFICATE OF DEATH.

8 4 E 18494

1-PLACE OF DEATH Baltimore JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. 7-9 ST., WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Walters

(a) RESIDENCE NO. Dundalk Junction, Balt. Co. ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred 9 yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) ~~HUSBAND~~ WIFE of: Charles Walters

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years 42; Months; Days; If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Lancaster Co. Penna.

PARENTS
10 NAME OF FATHER: George Bryson
11 BIRTHPLACE OF FATHER (city or town) (State or country): Penna.
12 MAIDEN NAME OF MOTHER: Anna Dean
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penna.

14 Informant (Address): JOHNS HOPKINS HOSPITAL

15 Filed JAN 31 1927 19 G. HARRISON Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 29 R 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 26 R, 1927, to Jan 29 R, 1927, that I last saw h er alive on Jan 29 R, 1927, and that death occurred, on the date stated above, at 7 50 a. m.

The CAUSE OF DEATH* was as follows:
Organic brain disease
2 weeks (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Hypertension
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Dundalk Junction
Did an operation precede death? No Date of
Was there an autopsy? yes
What test confirmed diagnosis? autopsy
(Signed) F. I. Weinbrenner, M. D.
1-29-1927 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lancaster Penna — DATE OF BURIAL: Jan 31st 1927

20 UNDERTAKER: Leo G. Cook — ADDRESS: 1725 Pratt St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18495
1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

66 ✓

REGISTERED NO. E 18495

City of BALTIMORE: (No. South Baltimore General Hospital St. Ward) 1-31-27

2-FULL NAME John Snyder.

(a) RESIDENCE NO. 20 Ropewalk Lane. St. Ward
(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. 10 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

N. B.—WRITE PLAINLY, with UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.—See instructions on back of certificate.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 Color or Race: White.

5 Single, Married, Widowed, or Divorced, (write the word): Widower.

5a If ~~MARRIED~~, widowed, ~~DIVORCED~~ HUSBAND of ~~WIFE~~: Mary Snyder.

6 DATE OF BIRTH (month, day, and year): March 10, 1879.

7 AGE: Years 47 | Months 10 | Days 18 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Glass blower.
(b) General nature of industry, business, or establishment in which employed (or employer): 86
(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER: George H. Snyder.

11 BIRTHPLACE OF FATHER (city or town): Germany.
(State or country)

12 MAIDEN NAME OF MOTHER: Mary Schneider.

13 BIRTHPLACE OF MOTHER (city or town): Germany.
(State or country)

14 Informant: Mrs. Leach. (sister)
(Address) 3815 Walbrook Ave.

Filed JAN 31 1927 C. HARRISON JONES, M. D.
By R.R. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 28, 1927 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Otto M. Reinhardt M. D.
(Coroner)

1/31 19 27 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ..... mos., ..... ds. In the State ..... yrs., ..... mos., ..... ds.

Where was disease contracted, if not at place of death? 20 Ropewalk Lane. Jan. 28, 1927.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laudley Park Date of Burial: Jan 31 19 27

20 UNDERTAKER: Chas. L. Lewis & Son ADDRESS: 1501 E. Pratt

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18496

## CERTIFICATE OF DEATH.

91-002

E 18496

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1801 N. Appleton St. 15-21 Ward)

2-FULL NAME Amanda N. Thomas

(a) RESIDENCE NO. 1801 N. Appleton St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. __ mos. __ ds. How long in U. S., if of foreign birth? 7 yrs. __ mos. __ ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | white | Widow |

5a If married, widowed, or ~~divorced~~ ~~HUSBAND~~ of (or) WIFE of Lewis M. Thomas

6 DATE OF BIRTH (month, day, and year) Feby 27/1847

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 79 | 11 | 3 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of indnstry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) Va

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Va

(State or country)

12 MAIDEN NAME OF MOTHER Polly Monger

13 BIRTHPLACE OF MOTHER (city or town) Va

(State or country)

14 Informant Julia Fowler

(Address) 1801 Appleton St.

Filed _____ 19__

C. HARRISON JONES, M. D.

Registrar

JAN 31 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 30 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 3 27, to Jan 30 27,

that I last saw h__ alive on Jan 29, 27,

and that death occurred, on the date stated above, at 2 15 p. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 6 (Six) yrs. __ mos. __ ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) __ yrs. __ mos. __ ds.

18 Where was disease contracted? ✓

If not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) W. E. Hunt M. D.

, 19 (Address) 1111 Mount St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Moorattico Va — Date of Burial Jan 31 1927

20 UNDERTAKER Harry W. Ehlen — ADDRESS 1914 W. North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18497

## CERTIFICATE OF DEATH.

90 E 18497

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 925 N. Chapel St St., 7-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Vincent Kouba

(a) RESIDENCE NO. 925 N. Chapel St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances Kouba

6 DATE OF BIRTH (month, day, and year) unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 59 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Bohemia

PARENTS

10 NAME OF FATHER Matej Kouba

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Bohemia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Frances Kouba

(Address) 925 N Chapel St

15 Filed JAN 31 1927 19 Harry [illegible] 14 Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 Jan 29/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocard tis (chr)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobular Pneumonia

(duration) yrs. mos. 14 ds.

(Signed) Jos S Botts, M. D.

(Coroner)

1/31/27 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Date of Burial Jan 31 1927

20 UNDERTAKER Frank Ecker & Son ADDRESS 1906 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18498

## CERTIFICATE OF DEATH.

129 E 18498

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 1226 N. Gay St., 9-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vincent F. Savilisky

(a) RESIDENCE NO. 1226 N. Gay St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? 44 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna M. Savilisky

6 DATE OF BIRTH (month, day, and year) July 2, 1859

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 67 | 6 | 28 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Coal Miner

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER Frances Savilisky

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Anna M. Savilisky

(Address) 1226 N. Gay St.

JAN 31 1927

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 1 1926, to Jan 29 1927, that I last saw h... alive on Jan 29 1927, and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthenia

Chr Int Nephs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) 1 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? None Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John Silverman M.D.

, 19 (Address) 1126 W Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Date of Burial Feb 1 1927

20 UNDERTAKER Mr & Mrs John N. Teufel & Son ADDRESS 801 W. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—No.—200 Bks.

199299

E 18499

1-PLACE OF DEATH

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

38 ✓

E 18499

REGISTERED NO.

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL 27-56 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Pascucci

(a) RESIDENCE NO. 4923 Park Heights Ave. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced. (write the word): single

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): 10/10 1885

7 AGE — Years: 41 — Months: 3 — Days: 19 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Barber

(b) General nature of industry, business, or establishment in which employed (or employer): 004

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Italy

PARENTS

10 NAME OF FATHER: Theodore Pascucci

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Italy

12 MAIDEN NAME OF MOTHER: Rosa ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Italy

14 Informant: Records

(Address): JOHNS HOPKINS HOSPITAL

15 Filed JAN 31 1927 C. HARRISON JONES, M. D. Registrar

By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927: Jan. 29

17 I HEREBY CERTIFY, That I attended deceased from Jan 16, 1927, to Jan 29, 1927, that I last saw h[illegible] alive on Jan. 29, 1927, and that death occurred, on the date stated above, at 5 45 P. m.

The CAUSE OF DEATH* was as follows:

Syphilis

Syphilitic aortitis

Aortic insufficiency

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Myocardial Insufficiency

(duration) yrs. 2 mos. ds.

IS Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Ex.

(Signed) Milton Sherry, M. D.

, 19 (Address) J Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — Date of Burial 2/1 1927.

20 UNDERTAKER: George J. Ruth — ADDRESS 1735 Harford ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—1-12-23—MAT—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18500 E 18500

## CERTIFICATE OF DEATH.

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 928 N. Calvert ST., 11-15 WARD)

2-FULL NAME Henrietta Cook

(a) RESIDENCE NO. 928 N. Calvert ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 ? yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Parker Cook

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 60 ? | -- | -- | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Conrad Siegman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Henrietta Meyer

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant H. W. Mears & Son
(Address) 805 N. Calvert Street

15 Filed JAN 31 1927 C. HARRISON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov. 13, 1927, to Jan 28, 1927.

that I last saw her alive on Jan 28, 1927.

and that death occurred, on the date stated above, at 5 30 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis,
Chronic Nephritis.
Hypertension

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. 2 mos. 16 ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of ~

Was there an autopsy? No

What test confirmed diagnosis? P.E.

(Signed) John S. Bishop, M. D.

, 19 (Address) 930 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery

DATE OF BURIAL 1/31 1927

20 UNDERTAKER Henry W. Mears & Son

ADDRESS 805 N. Calvert

N. B.—WRITE LEGIBLY. Spaces must be filled in with full information, should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 18501 48

# HEALTH DEPARTMENT—CITY OF BALTIMORE 38

## CERTIFICATE OF DEATH.

E 18501

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST. 16-22 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James L- Barkley

(a) RESIDENCE No. 1023 N. Stricker St ST., ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5yr yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, ~~or Divorced (write the word)~~:

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 21/26

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 1 Weeks 0 | 1 | 38 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): Col

(c) Name of employer

9 BIRTHPLACE (city or town) Balto- Md
(State or country)

PARENTS

10 NAME OF FATHER C. Barkley

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Ellen Cole

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed JAN 3 1927 C. HANSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 28 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan 11, 1927, to Jan 28, 1927, that I last saw h~~e~~ alive on Jan 28, 1927, and that death occurred, on the date stated above, at 4 15 P m.

The CAUSE OF DEATH* was as follows:

Syphilis

(duration) ..... yrs. 1 mos ..... ds.

CONTRIBUTORY
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thomas W. Cornell, M. D.

, 19 Address Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Laurel Cemetery | 1/30/27 |
| 20 UNDERTAKER Wm R. G. Elliott | ADDRESS 1725 Ashland |

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 18502

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18502

## CERTIFICATE OF DEATH.

151

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1113 N. Caroline St. ST. 8-13 WARD)

2-FULL NAME Emma M. Wetherill

(a) RESIDENCE NO. 1113 N. Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, ~~Married~~, Widowed, or ~~Divorced~~, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — —

6 DATE OF BIRTH (month, day, and year) Nov 29. 1850

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 76 | 2 | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Buckeystown Penna

PARENTS

10 NAME OF FATHER Solomon S. Wetherill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Doylestown Penna

12 MAIDEN NAME OF MOTHER Jane Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Doylestown Penna

14 Informant Mrs Lizzie Wetherill (Address) 1113 N Caroline St

15 Filed JAN 31 1927 19 C. HARRY JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 29 • 1927

17 I HEREBY CERTIFY, That I attended deceased from Jany 22. 1927. to Jany 29. 1927.

that I last saw her alive on Jany 29 1927.

and that death occurred, on the date stated above, at 10.40 P. m.

The CAUSE OF DEATH* was as follows:

Uremia - causing Coma

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis? Physical

(Signed) J. H. Thomas M. D.

Jany 31 1927 (Address) 1126 Decatur

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Memorial Cemetery, Coppistown, Harford Co. DATE OF BURIAL Feby 1 1927

20 UNDERTAKER John B. Spence ADDRESS 1323 N Caroline St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18503

## CERTIFICATE OF DEATH.

5 | E 18503

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2210 Brunt St. 14-20 Ward)

2-FULL NAME Charles Lee

(a) RESIDENCE NO. 2210 Brunt St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: C

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6-13-1877

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 49 | 6 | 17 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Upholsterer

(b) General nature of industry, business, or establishment in which employed (or employer): 085

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md

PARENTS

10 NAME OF FATHER Hannibal Lee

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country) Md

12 MAIDEN NAME OF MOTHER Virginia Ridgely

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country) D.C.

14 Informant Birdie Lee

(Address) 2210 Brunt St

15 Filed JAN 31 1927 C. HARRISON JONES M. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-30 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan 26, 1927, to Jan 30, 1927,

that I last saw him alive on Jan 30, 1927,

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Acute Inflamatory Rheumatism

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Acute Endocarditis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Marcellus L. Stone, M. D.

, 19 (Address) 1 Y's Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Gross — Date of Burial: Feb 2nd 1927

20 UNDERTAKER: Thomas E. Wright — ADDRESS: 1364 W. Baltimore St.

N. B.—WRITE PLAINLY, WITH LEAD PENCIL. The Certificate must be filled out in full as to every question. Each question should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 18504

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

101-001

E 18504

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home & Infir St. 6-9 Ward)

2-FULL NAME Mary Pazdzinska

(a) RESIDENCE NO. Edgemere, Md St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | white | married |

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Pazdzinska

6 DATE OF BIRTH (month, day, and year) 1897

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 30 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Frank Pazdzinska

(Address) Edgemere Md.

JAN 31 1927 C. HARRISON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 28/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Pneumonia (lobar)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. C. Pazdzinska M. D.
(Coroner)

1/30/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the state ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart of Mary Date of Burial Feb 1 1927

20 UNDERTAKER John M Weber ADDRESS 1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK. The items must be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 18505

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18505

## CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 3410 Dorall av, St. 15 61 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo Bunker - Sr.

(a) RESIDENCE. No. 3410 Dorall av St.. Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | White | Single - |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 1 1871

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 55 | 1 | 29 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER George Bunker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louise Kuhn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Wm Bunker

(Address) 3410 Dorall av

15 Filed ..... 19 ..... Registrar

JAN 31 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/30/ 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan 6th, 1927, to Jan 30, 1927, that I last saw h alive on Jan 30, 1927, and that death occurred, on the date stated above, at 4:00 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

a few hrs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Don't know

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W K Gorsuch M. D.

1927 (Address) 117 W Saratoga St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Baltimore | Feb 2. 1927 |

| 20 UNDERTAKER | ADDRESS |
|---|---|
| Wm Cook | 502 E North Ave |

CAUSE OF DEATH in plain terms, so that it may be properly classified. INFORMATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

# E 18506

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

× 31

E 18506

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. University Hospital St. 18-26 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raymond Fortney

(a) RESIDENCE NO. 867 W. Fayette St. Ward Glenburn Md
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): March 16, 1910

7 AGE — Years: 16 Months: 10 Days: 14 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Student

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Ohio

PARENTS

10 NAME OF FATHER: Geo. Fortney

11 BIRTHPLACE OF FATHER (City or town) (State or country): Ohio

12 MAIDEN NAME OF MOTHER: Emma Grub

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ohio

14 Informant: Thos. E Lace

(Address): 807 W Fayette St

15 JAN 31 1927 C. HAMPSON JONES, M. D. Registrar

Per MRD

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 30 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1927 to Jan 30, 1927

that I last saw h[im] alive on Jan 30, 1927.

and that death occurred, on the date stated above, at 2:20 P. m.

The CAUSE OF DEATH* was as follows:

Diffuse Bilateral Bronchopneumonia

Dengue.

(duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not Known.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms.

(Signed) J. D. Blackley M. D.

, 19 (Address) Municipal Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Denton, Caroline Co Md — Date of Burial: Jan 31 1927

20 UNDERTAKER: W. M. Cook — ADDRESS: 507 E. Ha...

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should state ... tion should be carefully supplied. AGE should be stated EXACTLY. ... OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 18507.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18507

## CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 23 W Spring ave ST. 27-5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fredk Charles Kluge

(a) RESIDENCE NO. 23 W. Spring ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. da. How long in U. S., if of foreign birth? 34 yrs. mos. da.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna Kluge

6 DATE OF BIRTH (month, day, and year): Nov 6 1875

7 AGE: Years 51 | Months 2 | Days 23 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer /

014

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Wilhelm Kluge

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Emma Schickes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Anna Kluge

(Address) 23 W. Spring Ave.

JAN 31 1927 File C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jany 29 1927

17 I HEREBY CERTIFY, That I attended deceased from July 6 1926 to Jany 29 1927

that I last saw h in alive on Jany 28 1927

and that death occurred, on the date stated above, at 11.30 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 3 yrs. — mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) C. Gustav Dill M. D.

1/30 1927 (Address) 1809 W Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem'y

DATE OF BURIAL: Feb. 1. 1927

20 UNDERTAKER: C. W. Dill

ADDRESS 309 Fredk Ave

B—WRITE PLAINLY, with pencil or pen and ink. AGE should be stated EXACTLY. This information should be carefully supplied. AGE should be stated EXACTLY. This information should be carefully supplied. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

E 18508

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18508

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2116 Berlin St ST. [illegible] WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert Anderson Smith

(Residence in Baltimore: No. 2116 Berlin St. St.; 40 yrs., mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

| 3-SEX. | 4-COLOR OR RACE, | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) |
|---|---|---|
| Male | White | Married |

6-DATE OF BIRTH, Jan (Month) 7 (Day), 1864 (Year)

7-AGE, 63 yrs. 0 mos. 23 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Band Sawyer
(b) General nature of industry, business, or establishment in which employed (or employer): Furniture Factory

9-BIRTHPLACE, (State or Country), Washington DC

PARENTS.

10-NAME OF FATHER, Edward A Smith.

11-BIRTHPLACE OF FATHER (State or Country), Washington DC.

12-MAIDEN NAME OF MOTHER Elizabeth Davis.

13-BIRTHPLACE OF MOTHER (State or Country), Washington DC

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E. Smith

(Address) 2116 Berlin St.

15-

Filed JAN 31 1927

C. HAMPSON JONES, M. D. Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 30 (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 27 1927, to Jan 30 1927, that I saw him alive on Jan 29 1927, and that death occurred, on the date stated above, at 10th A m.

The CAUSE OF DEATH* was as follows:

Apoplexy; Complicating an acute bronchitis.

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arterial hypertension

(Duration) ? yrs. mos. ds.

(Signed) H Hammond Wheeler M. D.

Jan 30, 1927 (Address) Lakeland Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

| 19-PLACE OF BURIAL OR REMOVAL. | DATE OF BURIAL. |
|---|---|
| Lindenwald | July 7, 1927 |
| 20-UNDERTAKER Chas J Johnson | ADDRESS 1424 N Pine |

N.B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18509 V 122-001 E 18509

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

City of BALTIMORE: (No. ) St., 10-N Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Sapp

(a) RESIDENCE NO. 1021 Wilcox St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Clara Sapp

6 DATE OF BIRTH (month, day, and year) 1885 Oct 29 -

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 41 42 | 3 | 1 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Paper Hanger

(b) General nature of industry, business, or establishment in which employed (or employer) 052

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore County

PARENTS

10 NAME OF FATHER Thomas R. Sapp

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore County

12 MAIDEN NAME OF MOTHER Mary Kiesler

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Penna

14 Informant

(Address) Records

Filed 1927 C. HAMPSON JONES, M. D. Registrar

Rec'd

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 30 1927

17 I HEREBY CERTIFY, That I attended deceased from January 28, 1927 to January 30, 1927, that I last saw h~~im~~ alive on January 30, 1927, and that death occurred, on the date stated above, at 3.15 P m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of the Liver (Alcoholic)

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? General & Laboratory

(Signed) R. Hooper Lunt C, M. D.

Jan 31 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial Feb 2 1927

Bal Cemetery

20 UNDERTAKER Ralph J Bauer Jr ADDRESS 1742 N Fulton

31 1927

F. B.—WRITE PLAINLY, WITH UNFADING INK. This certificate should be made out in full by the undertaker, or person acting as such, and the statement of CAUSE OF DEATH should be certified to by the physician, if any, last in attendance upon the deceased. PHYSICIANS should state carefully and correctly the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 18510 (1982) — HEALTH DEPARTMENT—CITY OF BALTIMORE — E 18510

# CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL — REGISTERED NO. 90

CITY OF BALTIMORE: (No. ..... St. 22-29 ..... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isaac Wells

(a) RESIDENCE NO. 729 Dover ..... ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| male | col. | married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1898

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| 29 | | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Bill Wells

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Henrietta Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 1 31 1927 C. HAMPSON JONES, M. D. (Registrar)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 22 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec. 24, 1926, to Jan. 22, 1927, that I last saw h alive on Jan. 22, 1927 and that death occurred, on the date stated above, at 7:40 P m.

The CAUSE OF DEATH* was as follows:

Acute pericarditis. Pleuro endocarditis.
Myocardial insufficiency
Pulmonary infarction.

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wilson Sheaw, M. D.

. 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL JAN 31 1927 19

20 UNDERTAKER — ADDRESS

JOHNS HOPKINS HOSPITAL

MEDICAL BOARD OF BALTIMORE CITY. Approved. CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF CONDITION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

O.K. K Hampel
J Fredrick asst Coroner 1-1-27

E 18511

## CERTIFICATE OF DEATH.

E 18511 REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 322 W Preston St 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Swann

(a) RESIDENCE NO. 322 W Preston St Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: all

5 Single, ~~Married~~, ~~Widowed~~, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 29, 27

| 7 AGE | Years | Months | Days | IF LESS than 1 day ~~hrs.~~, or ~~1 hr.~~ min. |
|---|---|---|---|---|
| | 20 Hours | | | 20 |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: no

(b) General nature of industry, business, or establishment in which employed (or employer): no

(c) Name of employer: no

9 BIRTHPLACE (city or town): Baltimore

(State or country): Maryland

PARENTS

10 NAME OF FATHER: James Swann

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Maryland

12 MAIDEN NAME OF MOTHER: Angie Ford

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Maryland

14 Informant

(Address)

15 Filed JAN 31 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 Jan. 29, 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 29, 1927 to Jan 29, 1927, that I last saw h~~im~~ alive on Jan 29, 1927, and that death occurred, on the date stated above, at 8:00 p.m.

The CAUSE OF DEATH* was as follows:

Drown in water in which it was found (accidental) no one with mother when baby was born (duration) ~~yrs.~~ ~~mos.~~ 20 ds.

CONTRIBUTORY (Secondary) Water in bucket home born (duration) ~~yrs.~~ ~~mos.~~ ~~ds.~~

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) G. F. Hall, M. D.

, 19 (Address) 426 E 23rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL Date of Burial 19

20 UNDERTAKER ADDRESS

Commissioner of Health JAN 31 1927

N.B.—WRITE PLAINLY with pen and ink. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N 31 1927 .0995

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 18512

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18512

## CERTIFICATE OF DEATH.

91-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4728 East Heights Ave (St.) 27-56 (Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rev John R. Joyner

(a) RESIDENCE. NO. 4728 East Heights Blvd ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos ds

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| male | White | Widower |

5a If married, widowed, or divorced HUSBAND of (~~or WIFE of~~) Carrie F Joyner

6 DATE OF BIRTH (month, day, and year) Sept 30 1843

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 83 | 4 | 0 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Minister

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Pitt Co. N. C.

PARENTS

10 NAME OF FATHER Noah Joyner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pitt Co N. C

12 MAIDEN NAME OF MOTHER Emily Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pitt Co. N. C.

14 Informant C. H. Joyner (Address) Thelma N. C.

Filed JAN 31 1927 19.. C. HARRISON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 11 1927 to Jan 30 1927.

that I last saw him alive on Jan 30 1927.

and that death occurred, on the date stated above, at 4.50 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Helen D Bubert M. D.

19 (Address) 4854 East Height Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Charles Town West Va — DATE OF BURIAL: Feb 1 19 27

20 UNDERTAKER: William Cook — ADDRESS: 502 E North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. Information as to CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE E 18513

## CERTIFICATE OF DEATH.

E 18513

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1028 Stonewood Ave. ST. 10-14 WARD)

REGISTERED NO. 89

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. J. Gordon

(a) RESIDENCE NO. 1028 Stonewood Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widower |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of The late Catherine A.

6 DATE OF BIRTH (month, day, and year) Jan 1856

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 71 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER James Gordon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Eliza Ann Parrott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Miss Nan Gordon (Address) 1028 Stonewood Ave.

15 Filed JAN 31 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 28 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 1 1926 to Jan 27 1927.

that I last saw him alive on Jan 25 1927 (about)

and that death occurred, on the date stated above, at 7 4 m.

The CAUSE OF DEATH* was as follows:

Cerebral Coronary artery Thrombosis

Lung Rt. Side from chronic Pleurisy (duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Angina (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) James M Denton, M. D.

(Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Holy Redeemer | Feb 1. 1927 |
| 20 UNDERTAKER | ADDRESS |
| Rita Wiedefeld | 914 Fremont Ave |

N. B.—WRITE PLAINLY, WITH CARBON PENCIL. AGE should be stated EXACTLY. Physicians are requested to fill out this certificate in full. All information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

Whiting

E 18514

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18514

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Walbert Apartments ST. 12-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dr. Henry Auchmuty Whiting

(a) RESIDENCE NO. Walbert Apartments ST., WARD President

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. 1 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lucie Colvin Whiting

6 DATE OF BIRTH (month, day, and year) December 30-1845

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 81 | 1 | 1 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer) Medicine 054

(c) Name of employer Self

9 BIRTHPLACE (city or town) New York

(State or country) New York

PARENTS

10 NAME OF FATHER Henry Yates Whiting

11 BIRTHPLACE OF FATHER (city or town) Paris

(State or country) Ohio

12 MAIDEN NAME OF MOTHER Mary Winter

13 BIRTHPLACE OF MOTHER (city or town) New Orleans

(State or country) Louisiana

14 Informant Mrs. Lucie C. Whiting, (wife)

(Address) Walbert Apartments, City.

15 Filed JAN 31 1927 C. HAMPSON JONES, M. D. Registrar

Rec'd

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 31st 1927

17 I HEREBY CERTIFY, That I attended deceased from March, 1921, to January 31st, 1927, that I last saw him alive on January 26th, 1927, and that death occurred, on the date stated above, at 11.45 a m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis; Hypertension

Symptoms (duration) 6 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Louis P. Hamburger, M. D.

January 31, 1927 (Address) 1207 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL (Brunswood Cemetery) Brooklyn, New York.

DATE OF BURIAL Feb — 27 19

20 UNDERTAKER STEWART & HOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

mation should be carefully supplied. AGE and
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

JAN 31 1927

Spec.—6-9-19—H. P. Co.—1000 Bks.

# E 18515

## HEALTH DEPARTMENT—CITY OF BALTIMORE

# E 18515

### CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2151 Wilkins ave ST. 30-12 (WARD)

REGISTERED NO. 100-31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Harry L. Bell

(a) RESIDENCE. No. 2151 Wilkins ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | white | Married |

5a If married, widowed or divorced
HUSBAND of [redacted] of Geraldine Hummel

6 DATE OF BIRTH (month, day, and year) July 14-1883.

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| 43 | 44 | 10 | 19 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Car Repair man.

(b) General nature of industry, business, or establishment in which employed (or employer) Machanic

(c) Name of employer United Railways

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph Bell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie Eichorn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mrs H. Bell.
(Address)

15 Filed JAN 31 1927 C. HAMPSON JONES, M. D. Registrar
By RKH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 25, 1927, to Jan 29, 1927, that I last saw him alive on Jan 29- 1927, and that death occurred, on the date stated above, at 8 00 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia /
Streptococcus /
Endocarditis.

CONTRIBUTORY (Secondary) Pulmonary Oedema (duration) yrs. mos. 5 ds.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Robert E Kitsch, M. D.

1/30/, 1927 (Address) 2151 Wilkins ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| New Cathedral Cemetary | Feb. 1 1927 |
| 20 UNDERTAKER | ADDRESS |
| Martin Fahey & Sons | 1827 W. North ave |

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DEATH is very important. See instructions on back of certificates.

JAN 31 1927

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18516

## CERTIFICATE OF DEATH.

187-007

E 18516

REGISTERED NO. _____

1-PLACE OF DEATH

City of BALTIMORE: (No. St Joseph Hospital St., 13-59 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph E? Wilson

(a) RESIDENCE NO. 1556 Clifton Ave St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 2 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosie E. Wilson

6 DATE OF BIRTH (month, day, and year) Nov 19 1877

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 49 | 2 | 11 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet maker

(b) General nature of industry, business, or establishment in which employed (or employer) Penna R.R.

(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md.

(State or country)

PARENTS

10 NAME OF FATHER Joseph Wilson

11 BIRTHPLACE OF FATHER (city or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Jennie Knapp

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Rosie E. Wilson

(Address)

15 JAN 31 1927 C. HAMPSON JONES, M. D.

Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30th 27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gas Gangrene- Shock
Accidental injury by electric drill thru left thigh near knee.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) _____ M. D.

(Coroner)

Jan. 30/27 (Address) 508 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Date of Burial Feb. 1 1927

20 UNDERTAKER Horace A. Burgee ADDRESS 363 Fallo Road

If the information called for in this section should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 18517 — 47 — E 18517

REGISTERED NO. 13-52

1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home & Infirmary St., Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Nannie M. Hitchcock.

(a) RESIDENCE NO. 1107 W. 32nd St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | married |

5a If married, widowed, or divorced (or) WIFE of Joseph C. Hitchcock

6 DATE OF BIRTH (month, day, and year) March 23-1872

| 7 AGE | Years | Months | Days | IF LESS than 1 day....hrs. or....min. |
|---|---|---|---|---|
| | 54 | 10 | 7 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 03

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryville Pa.

PARENTS

10 NAME OF FATHER Samuel A. Peacock

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Hester A. Piper

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Pennsylvania

14 Informant Joseph C. Hitchcock (Address) 1107 W. 32nd St.

15 FEB 3 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Jan 30, 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 26, 1927, to Jan. 30, 1927, that I last saw her alive on Jan 30, 1927, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial Failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cancer of breast

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? (Amputation of breast)

Did an operation precede death? yes Date of Jan 28, 1927

Was there an autopsy? no

What test confirmed diagnosis? Frozen section

(Signed) R. Clark Glove, M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Date of Burial Feb. 2 1927

20 UNDERTAKER Horace G. Burgee ADDRESS 63 Falls Rd

DON should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS are required to fill out CERTIFICATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N3

Cor.—12-9-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18518

## CERTIFICATE OF DEATH.

46

E 18518

1-PLACE OF DEATH

REGISTERED NO._____

City of BALTIMORE: (No. 531 Laurens St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Susie Hicks

(a) RESIDENCE NO. 531 Laurens St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | colored | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Hicks

6 DATE OF BIRTH (month, day, and year) April 4, 1873

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 53 | 9 | 25 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 27

(c) Name of employer

9 BIRTHPLACE (city or town) Va. Jan 30, 1927

(State or country)

PARENTS

10 NAME OF FATHER Wm. Moon

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va.

12 MAIDEN NAME OF MOTHER Benjamin Deacon

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Sarah Henderson

(Address) 531 Laurens St.

15 Filed C. HAMPSON JONES, M. D. Registrar

N 3 1927

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 29 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH was as follows:

Carcinoma of Cervix

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. T. Kennedy M. D.

(Coroner)

(Address) 280 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem. Date of Burial Feb 1 27

20 UNDERTAKER Grafton G. Gibson ADDRESS 1733 Druid Hill Ave

B.—WRITE INFORMATION PLAINLY. PHYSICIAN should be stated EXACTLY. PHYSICIAN should be carefully supplied. AGE should be tion should be carefully supplied. AGE should be stated in years, months and days. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

E 18519

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

11-0 E 18519

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Provident Hop St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara Scott

(a) RESIDENCE NO. 1213 Druid Hill Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. da. How long in U. S. if of foreign birth? yrs. mos. da.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Alfred Scott

6 DATE OF BIRTH (month, day, and year): Dec 1887

7 AGE: Years 39 Months 1 Days

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer): Private

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER: Lee Wells

11 BIRTHPLACE OF FATHER (City or town): Virginia

(State or country)

12 MAIDEN NAME OF MOTHER: Callie Greenfield

13 BIRTHPLACE OF MOTHER (city or town): ?

(State or country) Md

14 Informant (Address) Mrs Theresa Greene Washington D.C.

C. HAMPSON JONES, M. D. Registrar

Rec'd

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-28-1927

17 I HEREBY CERTIFY, That I attended deceased from 1-24, 1927, to 1-28, 19..,

that I last saw h.. alive on 1-26, 19..,

and that death occurred, on the date stated above, at 3.45 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

Myocarditis

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Nephritis + Influenza

(duration) yrs. mos. 12 da.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Dr. Ross Saunders M. D.

, 19 (Address) 1029 Stricker St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baldor Md Date of Burial Feb 1 19 27

20 UNDERTAKER: Samuel Stanley ADDRESS 5 Eddie St

N. B.—WRITE PLAINLY with pen and ink. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is very important. See instructions on back of certificates.

JAN 31 1927

Spec.—1-10-21—M&T—1500 Bks.

E 18520

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18520

## CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Maryland General Hospital

CITY OF BALTIMORE: (No. ..... ST. 1359 WARD)

2-FULL NAME Jesse Talbott

(a) RESIDENCE NO. 2018 Woodbury Ave ST., ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. 6 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 6, 1909

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 17 | 5 | 24 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER William H. Talbott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md.

12 MAIDEN NAME OF MOTHER Ida F Legrey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, Md.

14 Informant Hospital Record

(Address)

15 C. HAMPSON JONES, M. D. Registrar

3 1 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 27, 1927, to Jan 30, 1927, that I last saw him alive on Jan. 30, 1927, and that death occurred, on the date stated above, at 11:55 A m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Home (?)

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno A Thompson M. D.

, 19 (Address) 1 W Mt Vernon Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Forest Cem Balto Md

DATE OF BURIAL Feb 1 1927

20 UNDERTAKER E L Stiffler

ADDRESS 1252 North Ave

mation should be carefully supplied. Age should be stated in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

179

E 18521

## CERTIFICATE OF DEATH.

E 18521

REGISTERED NO. 23-32

1-PLACE OF DEATH

City of BALTIMORE: (No.) South Baltimore General Hospital (St.) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry L. Dammann.

(a) RESIDENCE NO. 18 E. Barney St. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 7 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male. | White. | Single. |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) June 21 1923.

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or....min. |
|---|---|---|---|---|
| | 3 | 7 | 9 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Henry F. Dammann.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Ruby E. Willis.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore, Md.

14 Informant Ruby E. Dammann. (mother)

(Address) 18 E. Barney St.

Filed FEB - 1 1927 C. HAMPSON JONES, M. D. Registrar

Pw

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 30, 1927. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns about the body while playing with matches. Accidental death.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

(Signed) Otto Leonhardt

1/31 1927 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

18 E. Barney St. Jany. 25, 1927.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Date of Burial Feb 1 1927

20 UNDERTAKER F. A. Holzapfel & Son ADDRESS 703 Fremont

(1) Fill out should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 18522

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18522

## CERTIFICATE OF DEATH.

REGISTERED NO. 27-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2706 Charlotte Ave. 15-56 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James W. Paca

(a) RESIDENCE NO. 2706 Charlotte ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ida Paca

6 DATE OF BIRTH (month, day, and year): June 20 1854

7 AGE: Years 72 | Months 7 | Days 9 | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Builder

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Not given

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Mrs Blanche Mertz

(Address) 601 Allendale st

Filed FEB 1 1927 HARRY H. JONES, M. D. Registrar

By [illegible]

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 29, 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1926 to Jan 29, 1927.

that I last saw living alive on Jan. 29, 1927

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 4 yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) R. C. Metzel, M. D.

1/30/1927 (Address) 1903 W. North ave,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

DATE OF BURIAL: Feb 1 1927

20 UNDERTAKER: F. A. Krause & Son

ADDRESS: 703 Hanover

IMPORTANT—This Certificate should be CAREFULLY EXAMINED. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—F-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

75-802 E 18523

E 18523

## CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1622 Dk. ave ST. 14-20 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thos. Miles

(a) RESIDENCE NO. 1622 Dennell Hill ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nannie Miles

6 DATE OF BIRTH (month, day, and year) Unknown 1864

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 63 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Nannie Miles

(Address) 1622 Dennell Hill

15 Filed FEB 1 1927, 19 C. HAMPTON JONES, M.D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/29 1927

17 I HEREBY CERTIFY, That I attended deceased from 10/1-26, 1926, to 1/29, 1927,

that I last saw him alive on 1/29, 1927,

and that death occurred, on the date stated above, at 9 AM/PM

The CAUSE OF DEATH* was as follows:

Ac. Nephritis

and ~~Uremia~~ Paralysis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dan'l Chatts, M. D.

1/31, 1927 (Address) 2139 Dk ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dear Hill Cem

DATE OF BURIAL Feb 1 1927

20 UNDERTAKER John H. Tradewin

ADDRESS 1027 Dennell Hill

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18524

## CERTIFICATE OF DEATH.

40 ✓ E 18524

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospitals St. 27-31 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucile Ivora —

(a) RESIDENCE NO. 223 W Hill St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harry E Gross

6 DATE OF BIRTH (month, day, and year): [illegible] 1906

7 AGE: Years 18 19 | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework.

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town): Missouri

(State or country)

PARENTS

10 NAME OF FATHER Tom Clements

11 BIRTHPLACE OF FATHER (city or town) [illegible]

(State or country) [illegible]

12 MAIDEN NAME OF MOTHER Leander ?

13 BIRTHPLACE OF MOTHER (city or town) Missouri

(State or country)

14 Informant: Harry E Gross

(Address) 223 W Hill St

15 Filed [illegible] 19 C. HARRISON JONES, M. D. Registrar

By

FEB 1 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Jan. 28. 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1927 to Jan. 28, 1927, that I last saw her alive on Jan. 28, 1927 and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Pelvic Abscess - Pelvic Peritonitis, (2 weeks duration) Bilateral Tuboovarian Abscess

(duration) yrs. 1/2 mos. ds.

CONTRIBUTORY (Secondary) Surgical Shock, Shock -

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date Jan. 3, and 28, 1927

Was there an autopsy? No

What test confirmed diagnosis? Surgical Sign & Operation

(Signed) J. Blanchard, M. D.

, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary — Date of Burial: Feb 1 1927

20 UNDERTAKER: John H. Tradin — ADDRESS 1027 Druid Hill

(2) WHERE DEATH OCCURRED, whether in hospital, institution, or private residence, should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18525 E 18525

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 11 W White Ave ST. Hamilton 27-42 WARD) REGISTERED NO. 2001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Conrad Schmick

(a) RESIDENCE No. 11 W White Ave ST., ..... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. / mos. / ds. How long in U. S., if of foreign birth? 48 yrs. / mos. / ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~: Catherine Schmick

6 DATE OF BIRTH (month, day, and year): Nov 22, 1870

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| 56 | | 9 | 7 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Conrad Schmick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. Catherine Schmick

(Address) 11 W. White Ave

15 Filed FEB - 1 1927 G. HAMPSON JONES, M. D. Registrar

Per R.R.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 29 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1927, to Jan 29, 1927, that I last saw him alive on Jan 29, 1927 and that death occurred, on the date stated above, at 6:15 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. 9 mos. 19 ds.

CONTRIBUTORY (Secondary): Hemiplegia

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Clinical

What test confirmed diagnosis?

(Signed) Henry L. Gray M. D.

Jan 29 1927 (Address) 2718 Hartsdale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Feb 1 1927

20 UNDERTAKER: Louis Heimann — ADDRESS: 325 Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. Professional CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

60-001

E 18526

## CERTIFICATE OF DEATH.

E 18526

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 404 N Montford Ave ST., 6-10 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hattie Schultz

(a) RESIDENCE NO. 404 N Montford ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frederick Schultz

6 DATE OF BIRTH (month, day, and year): June 8-1874

7 AGE: 53 Years: 52 Months: ... Days: 2 If LESS than 1 day, ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home 037

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER Edw Mueller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER Elvina Baumgarten

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Frank Schultz

(Address) 404 N Montford Ave

FEB 1 1927 H. HANSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 31 1927

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1926, to Jan 30, 1927.

that I last saw h[illegible] alive on Jan 29, 1927.

and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Myocarditis Chronic

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Ed Opthalmic Goiter

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) John R Lemmon M. D.

(Address) 410 N Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem

DATE OF BURIAL: Feb 2 1927

UNDERTAKER: John Ulrich

ADDRESS: 2008 Orleans

AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18527

## CERTIFICATE OF DEATH.

101-001

E 18527

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1228 Belmont Ave. 9-46 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie C Weatherway

(a) RESIDENCE NO. 1228 Belmont Ave ST. WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry A Weatherway

6 DATE OF BIRTH (month, day, and year) Mar 21-1862

7 AGE 63 Years 65 Months 10 Days 8 If LESS than 1 day, ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... (State or country) Balto

PARENTS

10 NAME OF FATHER Adam Rumming

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Germany

12 MAIDEN NAME OF MOTHER Marie Fuerk

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Germany

14 Informant Mrs John Bohnlofsick

(Address) 1226 Belmont Ave

15 Filed FEB - 1 1927 H. HAMPSON JONES, M. D., Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 20th 1927 to Jan 29th 1927 that I last saw h alive on Jan 29th 1927 and that death occurred, on the date stated above, at 12-8 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) O W Stoner, M. D.

Jan 31 1927 (Address) 1701 E Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Saint Matthews Cem

DATE OF BURIAL Feb 1 1927

20 UNDERTAKER John Ulrich

ADDRESS 2008 Orleans

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION of DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Stahlman

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18528

## CERTIFICATE OF DEATH.

90 E 18528

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1826 Doner St., 19-28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Elizabeth Stahlman

(a) Residence No. 1826 Doner St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX female

4-COLOR OR RACE, white

5-~~Single~~, Married, Widowed, or ~~Divorced~~, (Write the word.) Widow

6-If ~~married~~, widowed, or ~~divorced~~ ~~HUSBAND~~ of (or) WIFE of Martin Stahlman

6-DATE OF BIRTH (month, day and year) Jan 6/59

7-AGE. 68 yrs. 24 mos. ds. If LESS than 1 day, ....hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Caspar Denhardt

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Carrie Connelly

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore

11- (Informant) Mary E. Miller

(Address) 1877 Ramsey st

13- Filed FEB 1 1927 C. HAMPSON JONES, M. D. Registrar. K.K.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 30/27

17- I HEREBY CERTIFY, That I attended deceased from Jan 18 1927 to Jan 30 1927

that I last saw h.e.r. alive on Jan 30 1927

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac dilatation and decompensation

(Duration) yrs. 1 mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic endocarditis

(Duration) about 4 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? manual test

(Signed) H. E. Knipp M. D.

2/1 1927 (Address) 1102 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill

DATE OF BURIAL. Feb. 1. 1927

20-UNDERTAKER Robt J. Lennie

ADDRESS 1442 N Broadway

Should be carefully supplied. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18529

## CERTIFICATE OF DEATH.

29 E 18529

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 62 S Carrollton av ST., 18-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George A Forsyth

(a) RESIDENCE NO. 62 S Carrollton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie E. Forsyth

6 DATE OF BIRTH (month, day, and year) Oct 10. 1858

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 68 | 8 | 21 | 19 |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Paper Hanger

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

PARENTS

10 NAME OF FATHER Franklin Forsyth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Minnie E. Forsythe

(Address) 62 S Carrollton av

FEB 1 1927 File C. HARRISON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-29 1927

17 I HEREBY CERTIFY, That I attended deceased from April 27. 1925. to Jan 29. 1927.

that I last saw him alive on Jan 29. 1927.

and that death occurred, on the date stated above, at 8 30 P m.

The CAUSE OF DEATH* was as follows:

Hemaphalegia 2 days

Chronic Nephritis 9 mo.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 1 yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R Miller Hemming M. D.

1/30 1927 (Address) 2008 Hollins Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters

DATE OF BURIAL Feb 2 1927

20 UNDERTAKER John Wright Fuller

ADDRESS 1200 N Fremont

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.
CAUSE OF DEATH in plain terms, so that it may be properly classified.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

74-001

E 18530

REGISTERED NO. E 18530

E 18530
1-PLACE OF DEATH

City of BALTIMORE: (No. 1012 Hanover St. St. 23-31 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ida E. Young.

(a) RESIDENCE NO. 1012 Hanover St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 10 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female. | White. | Widow. |

5a If ~~Married, Widowed or Divorced~~ (or) WIFE of Charles Young.

6 DATE OF BIRTH (month, day, and year) March 9, 1858.

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 68 | 10 | 22 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sales lady.

(b) General nature of industry, business, or establishment in which employed (or employer) Department store.

(c) Name of employer Henry Hessell Co.

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER ----- McMillen.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Do not know.

14 Informant Anna Hartwig.

(Address) 1012 Hanover St.

15 Filed ..... 19 ..... Registrar

FEB 1 1927

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 31, 1927. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemiplexy.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) (duration) .....yrs. .....mos. .....ds.

(Signed) Otto Reinhardt M. D.
(Coroner)

1/31, 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State .....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem. Date of Burial Feb 2 1927

20 UNDERTAKER H. J. Johnson Sons ADDRESS [illegible]

If the certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18531

## CERTIFICATE OF DEATH

90

E 18531

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3312 Wallbrook Ave St. 15-67 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Knell

(a) RESIDENCE NO. 3312 Wallbrook Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 77 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Knell

6 DATE OF BIRTH (month, day, and year) Mar 1. 1849

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 77 | 10 | 28 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Food Inspector

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer City of Baltimore

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Henry Knell

11 BIRTHPLACE OF FATHER (city or town) Germany

(State or country)

12 MAIDEN NAME OF MOTHER Mary M. Krager

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Md.

14 Informant Mrs. Mary E. Knell

(Address) 3312 Wallbrook Ave.

15 Filed FEB - 1 1927 G. H[illegible] Registrar

Per KK

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 29 19 27

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 19 26 to Jan 29 19 27

that I last saw h-im alive on Jan 28 19 27

and that death occurred, on the date stated above, at 7 45 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Myocarditis

High blood pressure

(duration) 2 yrs. mos. ds.

CONTRIBUTORY Myocarditis

(Secondary)

(duration) 1 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) W. S. Tubbett, M. D.

2/1/27 19 (Address) 222 Garrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery Date of Burial Feb. 2 1927

20 UNDERTAKER Wm. J. Tucker & Sons ADDRESS North Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18532

## CERTIFICATE OF DEATH

90

REGISTERED NO. E 18532

1-PLACE OF DEATH

City of BALTIMORE (No. 1935 W. Mulberry St. 2-0-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Edward Hartley

(a) RESIDENCE NO. 1935 W. Mulberry St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | White | Married. |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret M. Hartley

6 DATE OF BIRTH (month, day, and year) Oct. 13 1880

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min.. |
|---|---|---|---|---|
| | 46 | 3 | 18 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Night Supervisor

(b) General nature of industry, business, or establishment in which employed (or employer) of Transportation

(c) Name of employer B & O R. R. Co's

9 BIRTHPLACE (city or town) Bladensburg

(State or country) Md

PARENTS

10 NAME OF FATHER Geo. Edw. Hartley

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah E. Chaney

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Mrs. May H. McFarland

(Address) Hyattsville Md

Filed FEB - 1 1927 19 HAMPSON JONES, M. D. Registrar

By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31 19 27

17 I HEREBY CERTIFY, That I attended deceased from Jan 30 19 27 to Jan 31 19 27

that I last saw him alive on Jan 30 19 27

and that death occurred, on the date stated above, at 12.30 a m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(duration) yrs. 1 mos. da.

CONTRIBUTORY (Secondary) Idiopathic Heart Hypertrophy

(duration) 2 yrs. mos. da.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Martin E Trautman M. D.

2/1 19 27 (Address) 2002 N Fremont

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Evergreen Cem Bladensburg Md | Date of Burial Feb 3 19 27

20 UNDERTAKER W J Tschiffely Sons | ADDRESS North Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

# E 18533 HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

## CERTIFICATE OF DEATH.

E 18533
REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Balto City Hospl 6-9

CITY OF BALTIMORE: (NO.) Balto Md (ST.) (WARD)

2-FULL NAME Samuel Stein

(a) RESIDENCE NO. 1733 E. Fairmount Ave (WARD)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Rose Stein

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 29 — Months: — Days: — If LESS than 1 day, ....hrs or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work:

(b) General nature of industry, business, or establishment in which employed (or employer): Tailor

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Nathan Stein

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Rachael Freeland

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Balto City Hosp
(Address) Balto Md

15 Filed FEB - 1 1927 E. HARRISON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1-31 1927

17 I HEREBY CERTIFY, That I attended deceased from 1-15 1927, to 1-31 1927,
that I last saw him alive on 1-31 1927,
and that death occurred, on the date stated above, at 2.40 P. m.

The CAUSE OF DEATH* was as follows:

Terminal Bronchio Pneumonia
and Cardiac Exhaustion
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Manic Depressive Psychosis
Manic & Depressive type
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Lo Dount M. D.

19 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Int Carmel

DATE OF BURIAL: 2-1 1927

20 UNDERTAKER: Jack Louis

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 18534

## CERTIFICATE OF DEATH.

REGISTERED NO. E 18534

1-PLACE OF DEATH

City of BALTIMORE: (No. 2729 E. Madison St. 7-12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert V. Holland

(a) RESIDENCE NO. 2606 E. Chase St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Widowed

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: Mary A. Holland

6 DATE OF BIRTH (month, day, and year): Jan 22nd 1862

7 AGE — Years: 65 — Months: — Days: 4 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Chief 030

(b) General nature of industry, business, or establishment in which employed (or employer): Engineer

(c) Name of employer

9 BIRTHPLACE (city or town): Balto Md

(State or country)

PARENTS

10 NAME OF FATHER: Holland

11 BIRTHPLACE OF FATHER (city or town): Balto

(State or country)

12 MAIDEN NAME OF MOTHER: —

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country)

14 Informant: Robert V. Holland

(Address): 2606 E. Chase St

FEB 1 1927

Filed ..... 19..

H. HAMPSON JONES, M. D.

Per ..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 29th 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 22 1927 to Jan 29 1927.

That I last saw h.. alive on Jan 28 1927,

and that death occurred, on the date stated above, at 6.45 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary): Edema of lungs

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm J Schmot, M. D.

1/29, 1927 (Address) 701 N Eutaw Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel — Date of Burial: Feb 1st 1927

20 UNDERTAKER: Philip Lewis — ADDRESS: Greenmt

tion should be carefully supplied. Age should be stated in years, months and days. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

18535

# HEALTH DEPARTMENT—CITY OF BALTIMORE

18535

## CERTIFICATE OF DEATH

90

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1252 N. BROADWAY St. 8-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William C. Ferguson.

(a) RESIDENCE NO. 1252 N. BROADWAY St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| MALE | WHITE | MARRIED |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Ferguson.

6 DATE OF BIRTH (month, day, and year) June 24 1846

7 AGE Years 7 Months 5 Days

80 1846 JUNE 24

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work RET'D. MERCHANT

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Co. Md.

(State or country)

PARENTS

10 NAME OF FATHER Nicol. Ferguson

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Mary Edel...

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany.

14 Informant Mrs. Virginia.

(Address) 1252 N. Broadway.

15 Filed FEB 1 1927 19 C. Hampson Jones M.D. 19 Registrar

For

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 27, 1927, to Jan 29, 1927, that I last saw h alive on Jan 29, 1927, and that death occurred, on the date stated above, at 5:30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage,

(duration) 4 yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. Hampson Jones, M. D.

Jan 30, 1927 (Address) 1834 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn, Cem. Date of Burial FEB 1, 1927

20 UNDERTAKER Hornberger Gross ADDRESS Fulton Ave

41

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill CAREFULLY and COMPLETELY every item of DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

74-001

E 18536
1-PLACE OF DEATH

REGISTERED NO. E 18536

City of BALTIMORE: (No. 2812 Guilford Ave St. 12-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hiram V. McCauley

(a) RESIDENCE NO. 2812 Guilford Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs E. McCauley

6 DATE OF BIRTH (month, day, and year) 1/4/64

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 62 | | 25 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER J. McCauley

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER M. McIntosh

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va.

14 Informant Mrs M McCauley

(Address) 2812 Guilford Ave

15 Filed ..... 19 ..... C. HARRISON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 29th 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 26 1926, to Jan 29th 1927

that I last saw him alive on Jan 29th 1927

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy & Paralysis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis and Dilated heart

(duration) 4 yrs. — mos. — ds.

18 Where was disease contracted —

If not at place of death? —

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Usual ones

(Signed) J. Stanley Gosnell M. D.

(Address) 1900 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem Date of Burial Jan 31 1927

20 UNDERTAKER J. J. Fahey & Son ADDRESS W. Lights

FEB - 1 1927

tion should be carefully supplied. Any unknown particulars must be stated. Exact statement of OCCUPATION is OF DEATH in plain terms, so that it may be properly classified. very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18537

## CERTIFICATE OF DEATH.

100-001

E 18537

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

REGISTERED NO.

City of BALTIMORE: (No. [redacted] St., 430 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John T. O'Brian

(a) RESIDENCE NO. 117 S Liberty Street Liberty St. near Lombard St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE: Years 43; Months; Days; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Maryland

PARENTS

10 NAME OF FATHER James O'Brian

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Ireland

12 MAIDEN NAME OF MOTHER Julia McClarkey

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Ireland

14 Informant

(Address) Records

15 Filed FEB-7 1927 C. HARRISON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 31 1927

17

I HEREBY CERTIFY, That I attended deceased from January 19, 1927, to January 31, 1927, that I last saw him alive on January 31, 1927, and that death occurred, on the date stated above, at 2.45 P m.

The CAUSE OF DEATH* was as follows:

Chronic & Acute Alcoholism

Alcoholic Neuritis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? general & laboratory

(Signed) R. Hooper Lamb, M. D.

Feb 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Date of Burial 2-2 1927

20 UNDERTAKER: Earl B Hale ADDRESS 115 E West St

tion should be carefully supplied. All space to be filled. Exact statement of OCCUPATION is OF DEATH in plain terms, so that it may be properly classified. very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18538

## CERTIFICATE OF DEATH.

E 18538

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No) 19 W. Overlea Avenue ST., 27 WARD) 27-42

2-FULL NAME Mary A. Seebold

(a) RESIDENCE NO. 19 W. Overlea Avenue ST., 27 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) December 9, 1842

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 84 | 1 | 21 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER Henry Seebold

11 BIRTHPLACE OF FATHER (city or town) Pennsylvania
(State or country)

12 MAIDEN NAME OF MOTHER Mary A. Stein

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant Miss Carrie Seebold
(Address) Overlea

15 Filed FEB 1 1927 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 30 1927

17 I HEREBY CERTIFY, That I attended deceased from January 28, 1927, to January 30, 1927,

that I last saw her alive on January 29, 1927,

and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. L. Wilkinson, M. D.

A. L. Wilkinson

1/31/27 (Address) 13 N. Belair Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Fairmount Cemetery DATE OF BURIAL Feb 4 1927

UNDERTAKER Frederick Sasaman & Son ADDRESS Fullerton

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupa-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

57 E 18539

REGISTERED NO.

E 18539

PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2527 Arunah Ave. ST. 16-68 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie K. Bockelman.

(a) RESIDENCE NO. 2527 Arunah Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late George Bockelman,

6 DATE OF BIRTH (month, day, and year) July 31, 1867

| 7 AGE Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|
| 59 | 5 | 29 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ...

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Maryland,

PARENTS

10 NAME OF FATHER Ferdinand W. Awalt,

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Elizabeth Degan

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany.

14 Informant Ferdinand W. Bockelman,
(Address) 3449 Old Frederick Road.

15 Filed FEB - 1 1927 19 G. HAMPTON JONES, M. D. Registrar

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29 1927

17 I HEREBY CERTIFY, That I attended deceased from March . 1926 . to Jan 29 . 1927 .

that I last saw her alive on Jan 28 . 1927 .

and that death occurred, on the date stated above, at 6.30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis - Diabetes Mellitus

Chronic Endocarditis & Pericarditis Uremic Coma

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Jorge H. Weare, M. D.

19 (Address) 4000 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Loudon Park Cemetery | Feb. 1 1927 |

| 20 UNDERTAKER | ADDRESS |
|---|---|
| Harry H. Witzke | 152 W. Lombard St. |

Spec.—1-12-23—M&T—500 Bks.

# E 18540 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129 E 18540

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2102 W Fayette ST. 20-69 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J Hirschel

(a) RESIDENCE NO. 2102 W Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Agnes Hirschel

6 DATE OF BIRTH (month, day, and year): June 21 1867

7 AGE: Years 59 Months 7 Days 9 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Plumber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Rev. Hirschel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Agnes Hirschel (Address) 2102 W Fayette St

15 Filed FEB - 1 1927 HARRISON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 30 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 1927 to Jan 30 1927

that I last saw h alive on Jan 29 1927

and that death occurred, on the date stated above, at 4:30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical tests

(Signed) M D Boyd, M. D.

1/31 1927 (Address) 1405 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem

DATE OF BURIAL: 2/2/27

19 UNDERTAKER: Joseph Shirley Fulton

ADDRESS: W Fayette

CAUSE OF DEATH to be written in ink or typewritten. TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18541

## CERTIFICATE OF DEATH.

66

E 18541

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 5-8 Ward)

2-FULL NAME William Cohen

(a) RESIDENCE NO. 909 Low St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. — mos. — ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah

6 DATE OF BIRTH (month, day, and year) unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 71 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired House Dealer

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) Russia

(State or country)

PARENTS

10 NAME OF FATHER Hirshel Cohen

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Russia

12 MAIDEN NAME OF MOTHER Chaia Rachil

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Russia

14 Informant Sarah Cohen

(Address) 909 Low st

15 FILED FEB - 1 1927 C. HAMPSON JONES, M. D.

Registrar

By _____

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/31 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan 9, 1927, to Jan 31, 1927, that I last saw him alive on Jan 31, 1927, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Myocardial failure

Chronic alcoholism

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic congestion

Lung (duration) yrs. mos. 7 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Max H. Crawford, M. D.

1 | 31 | 1927 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Hebrew Rest — Date of Burial 2/1 1927

20 UNDERTAKER Sol Levinson & Bro. — ADDRESS 112 Balto st

You should be careful that every answer is full and complete and that no space is left unfilled. Exact statement of OCCUPATION is very important. See instructions on back of certificate. Many deaths are improperly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. OF DEATH in plain terms, so that it may be properly classified.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18542

E 18542

## CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Pronounced dead at 7:20 P.M.

City of BALTIMORE: (No. Franklin Pg. Hos. St. Ward)

2-FULL NAME Wm R. Running

(a) RESIDENCE NO. 532 N. Payson St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 1 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine Agnes Running

6 DATE OF BIRTH (month, day, and year) Dec 11th 1883

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 43 | 1 | 18 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Hutzler Bros

9 BIRTHPLACE (city or town) Balto

(State or country)

PARENTS

10 NAME OF FATHER Herman Running

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Henrietta Dietrich

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Josephine A. Running

(Address) 532 N. Payson St.

Filed FEB - 1 1927 C. HARRISON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29 1927.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by Inquest (Inquest, autopsy or inquiry) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy at once

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Thos. B. Norton M. D. (Coroner)

Jan 30, 19 27 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See Instruction on back of Certificate.)

Bare Hills

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery Date of Burial Feb 2 1927

20 UNDERTAKER for Joordens & Son ADDRESS 217 S. Paca

tion should be carefully supplied. All items should be properly classified. Exact statement of OCCUPATION is OF DEATH in plain terms, so that it may be properly very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18543

CERTIFICATE OF DEATH.

E 18543

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. (T. B.) Ward) 12-25

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wade Burright

(a) RESIDENCE NO. 503 W. Franklin st. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1892

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 35 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Wade Burright

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER ? Pulley

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed FEB 1 1927, 19 HARRY W. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 January 29, 1927

17 I HEREBY CERTIFY, That I attended deceased from January 22, 1927, to January 29, 1927, that I last saw him alive on January 29, 1927, and that death occurred, on the date stated above, at 10.20 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) C. B. Latrobe, M. D.

1-29-27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Patricks Cemetery 2/11 19 27

20 UNDERTAKER J. J. Moran ADDRESS 3000 E. Baltimore

DUE ATTENTION is called to the fact that the answers to the questions on this certificate should be carefully prepared, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 18544

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

## CERTIFICATE OF DEATH.

E 18544

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1929 Wilhelm ST., 14-28 WARD)

2-FULL NAME Herman Schwartz

(a) RESIDENCE NO. 1929 Wilhelm ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 16, 1926

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | | 5 | 13 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Geo. H. Schwartz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Gertrude I.Seick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Geo. H. Schwartz

(Address) 1929 Wilhelm St.

FEB 1 1927 Filed

H. HARRISON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 30, 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan. 25, 1927, to Jan. 30, 1927.

that I last saw h im alive on Jan. 30, 1927

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Rickets 5 Mos.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia (broncho)

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw Hamilton, M. D.

1/31, 1927 (Address) 24 N. Fulton Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery

DATE OF BURIAL Feb. 1st 1927

20 UNDERTAKER George L. Schwartz

ADDRESS 2101 Eutaw Ave.

mation should be carefully supplied. Exact statement of OCCUPA-CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18545

161-002

## CERTIFICATE OF DEATH.

E 18545

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1825 Wilhelm St. 19-28 Ward)

2-FULL NAME Charles H. Hoffmann Jr

(a) RESIDENCE NO. 1825 Wilhelm St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 Color or Race: White | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Jan. 24-1927

7 AGE: Years | Months | Days: 6 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town): Balto. (State or country): Md.

PARENTS

10 NAME OF FATHER: Charles H. Hoffmann

11 BIRTHPLACE OF FATHER (city or town): Balto. (State or country): Md.

12 MAIDEN NAME OF MOTHER: Ada M. Bird

13 BIRTHPLACE OF MOTHER (City or town): Balto. (State or country): Md.

14 Informant: Mrs Estelle Purpus (Address) 1825 Wilhelm St

15 Filed FEB 1 1927 19 CHARLES J. KOBES, M. D. Registrar Per —

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/30/27

17 I HEREBY CERTIFY, That I attended deceased from 1/24/27, 19.., to 1/30/27, 19.., that I last saw h— alive on 1/30/, 19 27, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) —

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted? —

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? —

(Signed) Chas. J. Kobes, M. D.

3/1, 1927 (Address) 910 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cemetery Date of Burial: Feb. 1st 1927

20 UNDERTAKER: George L. Lohmeyer ADDRESS: 2101 Eutaw Ave.

One answer to each question, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

Fowls

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129

18546 E OF DEATH

REGISTERED NO. E 18546

City of BALTIMORE: (No. 217 Parrish St., 19-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mariah Lenieal Fowle

(a) RESIDENCE NO. 217 N. Parrish St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Whit Fowle

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years 92; Months; Days; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: [illegible]

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer

9 BIRTHPLACE (city or town): aurora

(State or country): N. C.

PARENTS

10 NAME OF FATHER: James Prichett

11 BIRTHPLACE OF FATHER (city or town)

(State or country): N. C.

12 MAIDEN NAME OF MOTHER: Recy Lindsay

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): N. C.

14 Informant: George Lenieal

(Address): 1555 W. Lexington St

Filed FEB - 1 1927 HARRY JOYES, M. D. Registrar

By [illegible]

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Jan - 29, 1927

17 I HEREBY CERTIFY, That I attended deceased from April 1st, 19 26, to Jan 29th, 19 27, that I last saw h[illegible] alive on Jan 28, 19 27, and that death occurred, on the date stated above, at 1, 15 4 m.

The CAUSE OF DEATH was as follows:

Mitral [illegible], Ch. [illegible] & Cl. Asphyxia

(duration) 2 yrs. 2 mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Place of Duty

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Mack Gordon, M. D.

, 19 (Address) 1631 W. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Zion Cemetery — Date of Burial: Feb. 1, 1927

20 UNDERTAKER: Mrs. Katie R. Williams — ADDRESS 322 N. Schroeder St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

E 18547

# HEALTH DEPARTMENT—CITY OF BALTIMORE

118-002

E 18547

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. West Baltic General Hos. 11-24 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Henry Groseling

(Residence in Baltimore: No. 843 Linden Ave. St.; yrs. 3 mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

| 3-SEX. | 4-COLOR OR RACE. | 5-Single, Married, Widowed, or Divorced. (Write the word.) |
|---|---|---|
| Male | Colored | Single |

6-DATE OF BIRTH. ..Unknown.. 1904
(Month) (Day) (Year)

7-AGE. 23 yrs. mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... R. R. Co.

9-BIRTHPLACE. (State or Country). Clio S. C.

PARENTS.

10-NAME OF FATHER. Mat Groseling

11-BIRTHPLACE OF FATHER. (State or Country) S. C.

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER. (State or Country) Unknown.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Groseling

(Address) 843 Linden Ave.

15-

Filed FEB 1 1927 C. HAMILTON JONES, M. D. Registrar.

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Jan. 30 1927
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Pulmonary Larynx.

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. T. Hammerson M. D.
(Coroner.)

Jan. 31 1927 (Address) 2 E. Lexington St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

| 19-PLACE OF BURIAL OR REMOVAL. | DATE OF BURIAL. |
|---|---|
| Clio S. C. | Feby 1 1927 |
| 20-UNDERTAKER. Samuel T. Hanley | ADDRESS 578 W. Baltimore |

state CAUSE OF DEATH in plain terms, so that it may be understood. Item 17 is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

E 18548

# HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 18548

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [illegible] St. 17-25 Ward)

REGISTERED NO. _____

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Emma Gibson

(a) RESIDENCE NO. 604 Bradley St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Negro | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alexander Gibson

6 DATE OF BIRTH (month, day, and year) 1883

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 44 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Maryland

PARENTS

10 NAME OF FATHER James White

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Emma —

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Maryland

14 Informant (Records)

(Address) _____

Filed. FEB - 1 19 27 C. HARRY JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 28 1927

17

I HEREBY CERTIFY, That I attended deceased from January 6 1927, to January 28, 1927, that I last saw her alive on January 28, 1927, and that death occurred, on the date stated above, at 5-30 P m.

The CAUSE OF DEATH* was as follows:

Coma Insulin Pneumonia

Chronic Myocarditis Insulin Pneumonia

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis? General Laboratory

(Signed) W W Coogan Smith, M. D.

Jan 29 1927 (Address) _____

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Date of Burial 2/1/1927

20 UNDERTAKER Samuel T Hawley & W Biddle ADDRESS 578

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 18549

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18549

## CERTIFICATE OF DEATH.

101-80

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 3 Dewey Ave ST. 27-53 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy F Hall

(a) RESIDENCE NO. 3 Dewey Ave ST., WARD

(Usual place of abode).

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Abraham Hall

6 DATE OF BIRTH (month, day, and year): Sept 1880

7 AGE: Years 46 Months 4 Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country): Richmond Va

PARENTS

10 NAME OF FATHER: John Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER: Lucian Jordan

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant: Abraham Hall

(Address) 3 Dewey Ave

15 Filed ..... 19 ..... Registrar

EB - 1 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 29 19 27

17

I HEREBY CERTIFY, That I attended deceased from Jan 28 1927 to Jan 29 19 27

that I last saw h alive on Jan 29 19 27

and that death occurred, on the date stated above, at 7 00 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R J Young M. D.

1/31, 19 27 (Address) 424 E monument st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL 2/1 19 27

20 UNDERTAKER: Samuel T Hemsley — ADDRESS 516 N Bridle

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT INFORMATION is very important. See instructions on back of certificates.

E 18550 Sp. Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

31

E 18550

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 223 Arch St. 4-25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Willett.

(a) RESIDENCE NO. 223 Arch St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. — mos. — ds. How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Cal.

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ernest Willett.

6 DATE OF BIRTH (month, day, and year): Aug - 15 - 1904

7 AGE — Years: 22 Months: 5 Days: 15 IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Waitress 070

(b) General nature of industry, business, or establishment in which employed (or employer): in a Confectionery Restaurant

(c) Name of employer: 412 Mulberry Cafe Charles

9 BIRTHPLACE (city or town)

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Unknown

12 MAIDEN NAME OF MOTHER: Annie Allen

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Unknown

14 Informant: Owner Restaurant

(Address) 223 Arch St

15 Filed FEB - 1 1927 C. HAMPSON JONES, M. D. Registrar

By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 30 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug - 1926, to Jan - 30, 1927, that I last saw h er alive on Jan 29 1927, and that death occurred, on the date stated above, at 8½ a. m.

The CAUSE OF DEATH* was as follows:

(a) Pulmonary Tuberculosis

(duration) yrs. 5 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted —

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Pulmonary T. B.

(Signed) Dan'l Deaver M. D.

1/31, 1927 (Address) 1422 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

Date of Burial: 2/3/1927

20 UNDERTAKER: Samuel T Hemsley

ADDRESS 578 W Biddle

Exact statement of OCCUPATION is necessary. Abbreviations should be carefully supplied. Avoid terms like laborer, clerk, etc. Occupation should be properly classified. Exact statement of OCCUPATION should be given in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-28—M&T—100 Bks.

E 18551

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

24-001

24 E 18551

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1400 McCulloh St., 14-20 WARD)

2-FULL NAME James Jones

(a) RESIDENCE NO. 1400 McCulloh ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown.

6 DATE OF BIRTH (month, day, and year) 1875

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs. or ....min. |
|---|---|---|---|---|
| | 52 | | | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Cook.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown. Jan. 30, 1927 (Address) 2 Fort Avenue

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Joseph P. Evans Jr. (Address) 1400 Evans St

15 Filed FEB - 1 1927 T. HARRISON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 29 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

cerebral hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) no history

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy, M. D. (Coroner.)

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death .... yrs., .... mos., .... ds. In the State .... yrs., .... mos., .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Lawn

DATE OF BURIAL 2/1 1927

20 UNDERTAKER Samuel T. Hennessy

ADDRESS 578 W Biddle

TION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

18552

## CERTIFICATE OF DEATH

101-001

E 18552

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 638 Wayne St. 27-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Gray

(a) RESIDENCE NO. 638 Wayne St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | Col | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mollie Gray

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..hrs. or ..min.. |
|---|---|---|---|---|
| | 58 | ? | ? | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Stevedore

(c) Name of employer Carlon Co.

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Celia Gross

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Mollie Gray
(Address) 638 Wayne

15 Filed ..., 19 ... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/29/ 19 27

17 I HEREBY CERTIFY, That I attended deceased from 1/19/27, to 1/29/27, that I last saw h... alive on 1/29/27, and that death occurred, on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows: Uremia

Labor Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Chronic nephritis

Bronchitis (duration) yrs. mos. 10 ds.

18 Where was disease contracted None

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno Buxley M. D.

1/31/ 19 27 (Address) 908 Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL McCauley

Date of Burial 2/1 19 27

20 UNDERTAKER Mrs Gad H Harper

ADDRESS 400 N Carey St

tion should be carefully supplied. Avoid ... OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 18553 114 Registered No. E 18553

1-PLACE OF DEATH

City of BALTIMORE: (No.) 825 Warren St. (1-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Norman Payne

(a) Residence No. 825 Warren St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

| 3-SEX. | 4-COLOR OR RACE. | 5-Single, Married, Widowed, or Divorced, (Write the word.) |
|---|---|---|
| Male | Col | [illegible] |

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 26 1919

7-AGE. 7 yrs. 8 mos. 3 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work [illegible]

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Md

PARENTS.

10-NAME OF FATHER. Edward Payne

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md

12-MAIDEN NAME OF MOTHER. Lula Lee

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md

14- (Informant) Lula Payne

(Address) 825 Warren St

15- Filed FEB 1 1927 19 HARRISON JONES, M. D. Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 1-29-27

17- I HEREBY CERTIFY, That I attended deceased from on 1-24 1927, to on 1-29 1927,

that I last saw him alive on on 1-29 1927,

and that death occurred, on the date stated above, at 11:40 P.M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Gastro Enteritis

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jno. A. Cooke, M. D.

, 19 (Address) 655 W Lee St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Auburn DATE OF BURIAL. July 2 19 27

20-UNDERTAKER. Mrs Geo A Hooper ADDRESS 416

In plain terms, so that everyone can understand, please read instructions on back of certificates.

Spec.—12-9-26—1 Co.—200 Bks.

1995 61 1

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

100-001

E 18554

REGISTERED NO. E 18554

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 5-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Artis

(a) RESIDENCE NO. 10 N. Caroline St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | col | |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 14th 1926.

| 7 AGE Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|
| | 2 | 10 weeks 17 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer

9 BIRTHPLACE (city or town).....
(State or country) Ind -

PARENTS

10 NAME OF FATHER Hersey Artis

11 BIRTHPLACE OF FATHER (city or town).....
(State or country) Va -

12 MAIDEN NAME OF MOTHER Ellie Lawrence

13 BIRTHPLACE OF MOTHER (city or town).....
(State or country) Va -

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

Filed FEB - 1 1927, 19 C. Heath Jones Registrar

By RJC

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 Jan. 31

17 I HEREBY CERTIFY, That I attended deceased from Jan 24, 1927, to Jan 31, 1927, that I last saw her alive on Jan 31, 1927, and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Prematurity 10 weeks

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 10 N. Caroline St.

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. E. Handley, M. D.

, 19 (Address) John Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery Date of Burial Feb. 1927

20 UNDERTAKER Jos. G. H. Rochester ADDRESS 1413 Hoffman St

DEATH In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

Carroll L Judy

E 18555 HEALTH DEPARTMENT—CITY OF BALTIMORE 20 E 18555

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4978 Edgemere ST. 27-56 WARD)

2-FULL NAME Carroll Lee Judy

(a) RESIDENCE NO 4978 Edgemere ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | White | Sing. |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 11/29/25

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 1 | 2 | 3 2 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Belo
(State or country) Mont

PARENTS

10 NAME OF FATHER E W Judy

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ky

12 MAIDEN NAME OF MOTHER Lillie Hendrix

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ind

14 Informant Ernest W Judy
(Address) 4978 Edgemere Ave

15 Filed FEB 1 1927 J. HAMPSON JONES, M.D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/31 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:
Strangulated ileus eating
Crust of bread

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) [signature], M. D.
(Coroner.)
1/31 1927 (Address) 1932 Rolandvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Mgmt DATE OF BURIAL Feb 2 1927

20 UNDERTAKER Edward Lee ADDRESS 723 N Lafayette Ave

Cause of death must be stated plainly. See instructions on back of certificate. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

E 18556

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18556

## CERTIFICATE OF DEATH.

57

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1822 Aliceanna ST. 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME AGNES LOREK,

(a) RESIDENCE NO. 1822 Aliceanna ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? 54 yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | White | Widow, |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Lorek,

6 DATE OF BIRTH (month, day, and year) Jan. 1- 1848.

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or min. |
|---|---|---|---|---|
| | 79 | | 30 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work, 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland,

PARENTS

10 NAME OF FATHER Unknown,

11 BIRTHPLACE OF FATHER (city or town) Poland, (State or country)

12 MAIDEN NAME OF MOTHER Lucy Chirkowska,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland,

14 Informant Mrs. Mary Nowakowski,

(Address) 1822 Aliceanna Street

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/31/1927

17 I HEREBY CERTIFY, That I attended deceased from 10/15, 1926, to 1/31, 1927,

that I last saw h alive on 1/30, 1927,

and that death occurred, on the date stated above, at 1030 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Mellitis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Gangrene

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Hampson Jones M. D.

, 1927 (Address) 932 S Ann St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ST. STANISLAUS CEMETERY

DATE OF BURIAL Feb, 3- 1927.

20 UNDERTAKER M. F. Sadowski.

ADDRESS 705 S. Ann St

Filed FEB 1 1927

HAMPSON JONES, M. D.

Registrar

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—12-9 25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18557

## CERTIFICATE OF DEATH.

11-001 E 18557

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1901 E.Lafayette Ave. St. 8-17 Ward)

2-FULL NAME Ida Aburn

(a) RESIDENCE NO. 1901 E.Lafayette Ave. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced
BUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct.3rd,1854

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 72 | 3 | 25 26 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER Johnson B.Aburn

11 BIRTHPLACE OF FATHER (city or town) Balto.

(State or country) Md.

12 MAIDEN NAME OF MOTHER Emily J.Smith

13 BIRTHPLACE OF MOTHER (city or town) Balto.

(State or country) Md.

14 Informant Mrs Mary Aburn

(Address) 1901 E.Lafayette Ave.

15 Filed..... 19 ..... Registrar.

FEB 1 1927 C. HARRIS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 January 29th,1927

17

I HEREBY CERTIFY, That I attended deceased from Dec 15, 19 26, to Jan. 29, 19 27,

that I last saw h..... alive on Jan. 27, 19 27;

and that death occurred, on the date stated above, at 11:20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis - Catarrh.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

Grippe (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Emily Patterson M. D.

, 19 (Address) 4223 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Baltimore Cemetery | 2/2/ 19 27 |
| **20 UNDERTAKER** | **ADDRESS** |
| E.I.Farming & Son 1938 | E.Lafayette |

Spec.—12-9-25—A Co.—200 Bks.

Cooman ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18558

## CERTIFICATE OF DEATH.

90 E 18558

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No._____ St. 16-21 Ward)

2-FULL NAME Michael Cooman

(a) RESIDENCE NO._____ St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single ? |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1840

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 67 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant

(Address) Records

15 Filed FEB 1 1927 C. HAMPSON JONES M. D. Registrar

By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 31 1927

17

I HEREBY CERTIFY, That I attended deceased from August 20, 1925, to January 31, 1927, that I last saw him alive on January 30, 1927 and that death occurred, on the date stated above, at 6 A.m.

The CAUSE OF DEATH* was as follows:

Cystical Sclerosis

Chronic Myocarditis & Insufficiency

(duration) ?yrs. mos. ds.

CONTRIBUTORY Myocardial Failure

(Secondary)

(duration) yrs. mos. 7 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? General Laboratory

(Signed) Edward Hooper Lantz, M. D.

Jan 31 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| New Cathedral Cemetery | 2/1 1927 |

20 UNDERTAKER ADDRESS

E. V. Fanning & Son 1600 Battery Ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec. -7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002 E 18559

E 18559

## CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1023 N. Central Ave St., 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin F. Leach

(a) RESIDENCE NO. 1023 N. Central Ave St. 10 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. — mos. — ds. How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | Wht | Married |

5a If married, widowed or divorced HUSBAND of (or) ~~WIFE of~~ Mary W. Leach

6 DATE OF BIRTH (month, day, and year) 1861 Jan

7 AGE Years 65 Months — Days — IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.

(State or country)

PARENTS

10 NAME OF FATHER Benjamin B. Leach

11 BIRTHPLACE OF FATHER (City or town) Balto Md

(State or country)

12 MAIDEN NAME OF MOTHER Sophia Hardy

13 BIRTHPLACE OF MOTHER (city or town) Balto Md

(State or country)

14 Informant Mrs Mary W. Leach

(Address) 1023 N Central Ave

15 Filed FEB - 1 1927 G. HARRISON JONES M.D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 Jan. 31st

17 I HEREBY CERTIFY, That I attended deceased from Jan 10th 1927 to Jan 31st 1927.

that I last saw him alive on Jan 30th 1927

and that death occurred, on the date stated above, at 3.12 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Senile Dementia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cystitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm S. Love, M. D.

Jan 31 1927 (Address) 1507 Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery Date of Burial Feb. 2nd 1927

20 UNDERTAKER Henry Hoech Son ADDRESS 1301 E Eager St

tion should be carefully supplied. AGE should be stated in... OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18560

## CERTIFICATE OF DEATH.

57 E 18560

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1701 N. Collington Ave. St. 8-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Daly

(a) RESIDENCE NO. 1701 N. Collington Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | White | Widow |

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph H. Daly

6 DATE OF BIRTH (month, day, and year) May 4th. 1862

| 7 AGE Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|
| 64 | 8 | 25 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Eugene Daly.

(Address) 1701 N. Collington Ave. C. HARRY JONES, M. D.

15 Filed [illegible] 19 [illegible] Registrar

EB - 1 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 29th. 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Jan 11 1927 to Jan 29 1927, that I last saw h[illegible] alive on Jan 29 1927, and that death occurred, on the date stated above, at 1.15 P m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilitation

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis Diabetis Mellitus Chronic Endocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. F. Duncan, M. D.

30, 19 27 (Address) 711 N Pat. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery. Date of Burial 2/2 29

20 UNDERTAKER Chas. F. Kraus & Son ADDRESS 118 W. Mt. Royal ave

OF DEATH in plain terms, so that it may be properly classified. Fill every item. Be very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

(Baumel)

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18561

## CERTIFICATE OF DEATH.

32

E 18561

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 1-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Baumel

(a) RESIDENCE NO. 130 S. Patterson Park Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 Color or Race W

5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~. (write the word) S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1914

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 12 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md

(State or country)

PARENTS

10 NAME OF FATHER Samuel Baumel

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER Pearl

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Samuel Baumel

(Address) 130 S. Patterson Park Ave

1192 C. HAMPSON JONES, M. D. Registrar

By —

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 1-31-27

17 I HEREBY CERTIFY, That I attended deceased from Jan 30, 1927, to Jan 31, 1927, that I last saw h[illegible] alive on Jan 31, 1927, and that death occurred, on the date stated above, at 11-30 P. m.

The CAUSE OF DEATH* was as follows:

~~Pneumonia~~

~~Pneumonia~~ ?

Cardiac failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial Abscess ?

Pneumonia ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Nat Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) Milton Krumfeld, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel — Date of Burial 2-1-1927

20 UNDERTAKER Jack Levin, 1139 Bank — ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18562

188-003 E 18562

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital St., 11-15 Ward)

2-FULL NAME Eva Rebecca Connelly

(a) RESIDENCE NO. 5 East Biddle St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. 1 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | white | single |

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of XXXXXXX

6 DATE OF BIRTH (month, day, and year) Dec 29/1892

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 34 | 1 | 1 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) Christian Science

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER David S. Connelly

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto., Co., Md.

12 MAIDEN NAME OF MOTHER Anna L Bosley

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Carroll Co., Md.

14 Informant David S. Connelly

(Address) 5 E. Biddle St.

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

By Asst

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 Jan 30/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock- Intrathoracic hemorrhage.
Struck by automobile at Biddle St & Fallsway on Jan 30/27.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) John H. Cain M. D.
(Coroner)

1/31/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery Date of Burial 2/2 1927

20 UNDERTAKER Geo. Weber & Son ADDRESS 2503 Edmondson Ave

OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF OCCUPATION very important. See instructions on back of certificate.

Dyer 12-23-21 E.B.P.S. 400 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18563

E 18563

## CERTIFICATE OF DEATH.

18-24 89

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 125 S. Arlington Ave St. ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Budesheim, George C.

(a) Residence No. 125 S. Arlington Ave Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE Fredericka M. Budesheim

6-DATE OF BIRTH (month, day and year) March 5, 1872

7-AGE 54
85 yrs. 1 mos. 12 ds.

If LESS than 1 day, ....hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Shoe maker

(b) General nature of industry, business, or establishment in which employed (or employer) 88

(c) Name of employer.....

9-BIRTHPLACE (City or town) (State or Country). Germy

PARENTS.

10-NAME OF FATHER Conrad Budesheim

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germy

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germy

14- (Informant) Fredericka M. Budesheim

(Address) 125 Arlington ave

15- Filed 1927 C. HAMPSON JONES, M. D. Registrar.

By ..... A.C.B.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) January 30, 1927.

17- I HEREBY CERTIFY, That I attended deceased from January 1 1927 to January 30 1927.

that I last saw him alive on January 29. 1927.

and that death occurred, on the date stated above, at 10.30 P m.

The CAUSE OF DEATH* was as follows:

Angina pectoris

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cardiac paralysis

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical symptoms

(Signed) F. C. Grund M. D.

Jan. 31. 1927 (Address) 904 N. Charles St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Stemmers Run

DATE OF BURIAL. Feb 2nd 1927

20-UNDERTAKER. E. Schloman & Son

ADDRESS 1034 Lemmon St.

instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 18564

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18564

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3009 Independence St. Ward 9-46)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry A Johnson

(a) RESIDENCE No. 3069 Independence St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha Johnson

6 DATE OF BIRTH (month, day, and year) Dec 6 1865

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min |
|---|---|---|---|---|
| | 61 | 1 | 25 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Salesman

(c) Name of employer

9 BIRTHPLACE (City or town) Lincoln Ill
(State or country)

PARENTS

10 NAME OF FATHER Ford Johnson

11 BIRTHPLACE OF FATHER (city or town) Lincoln Ill
(State or country)

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) Dont Know
(State or country)

14 Informant Mrs Bertha Johnson
(Address) 3009 Independence St

15 1 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1926, to Jan 31, 1927, that I last saw h alive on Jan 29 1926, 1927, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage.

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Robert S. Kirk M. D.

2/1, 1927 (Address) 3126 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Shipped to Rutherford N.J. then to Delaware Anna N.J. by auto

DATE OF BURIAL Feb 2 27

20 UNDERTAKER John F Denny.

ADDRESS 715 Eutaw St

TION is very important See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 18565

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH. 161-001

E 18565

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1546 Argyle ST. 14-20 WARD)

2-FULL NAME Baby Jackson

(a) RESIDENCE NO. 1546 Argyle ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | C | S |

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1·31·27

| 7 AGE | Years | Months | Days | If LESS than 1 day, 6 hrs. or ..... min. |
|---|---|---|---|---|
| | | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Andrew Leon Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Providence R.I.

12 MAIDEN NAME OF MOTHER Helen Esther Perry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Jacksonville Fla

14 Informant (Address)

15 1 1927 C. HAMPSON JONES, M. D. 19 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1, 31 1927

17

I HEREBY CERTIFY, That I attended deceased from 1·31 ,1927, to 1·31 ,1927,

that I last saw h— alive on 1·31 ,1927,

and that death occurred, on the date stated above, at 5:45 P m.

The CAUSE OF DEATH* was as follows:

Premature birth

(duration) yrs. 0 mos ds.

CONTRIBUTORY (Secondary) Malnutrition.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. L. Kerr M. D.

, 19 (Address) 1520 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| JOHNS HOPKINS HOSPITAL | 19 FEB 1927 |
| 20 UNDERTAKER | ADDRESS |

Commissioner Health.

Per [illegible] R. KOUBALL

TION is very important. See instructions on back of certificate

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18566

## CERTIFICATE OF DEATH.

E 18566

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 209 S Bouldin St., ST. 26-2 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August I. Zentgraf,
209 S. Bouldin St.

(a) RESIDENCE NO. ..... ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widowed |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Late Annie Zentgraf,

6 DATE OF BIRTH (month, day, and year) Aug. 22, 1852

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 74 | 5 | 8 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Baker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Md.

PARENTS

10 NAME OF FATHER Ignatiunas Zentgraf

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Sophie Roell,

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs. Charles Grabill,
(Address) 209 S Bouldin St.

15 Filed 1 1927 C. HAMPSON JONES, M. D. Registrar
By .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1927 to Jan 30, 1927
that I last saw h alive on Jan 30, 1927
and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. L. Campbell M. D.

Jan 31, 1927 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery — DATE OF BURIAL Feb. 2 1927

20 UNDERTAKER Harry A Wicks — ADDRESS N 3141 W Fond

CAUSE OF DEATH in plain terms. Abbreviations not allowed. Name of disease causing death must be stated. If death was due to external cause (violence) state the nature of injury, and whether accidental, suicidal or homicidal. If death was due to disease, state the duration of each disease. If death was due to childbirth, state whether before, during or after labor, and how long after labor. If death was due to a contagious disease, state whether case was reported to Health Department. If death was due to tuberculosis, state whether sputum was examined. If death was due to cancer, state whether a tumor was present. If death was due to violence, state whether coroner was notified. If death was due to a surgical operation, state the nature of operation and the date performed. If death was due to a fracture, state whether the fracture was compound or simple. If death was due to a burn, state whether the burn was first, second or third degree. If death was due to a poisoning, state the name of the poison and whether it was taken accidentally, suicidally or homicidally. If death was due to a drowning, state whether the drowning was accidental, suicidal or homicidal. If death was due to a hanging, state whether the hanging was accidental, suicidal or homicidal. If death was due to a gunshot wound, state whether the wound was accidental, suicidal or homicidal. If death was due to a stabbing, state whether the stabbing was accidental, suicidal or homicidal. If death was due to a blow, state whether the blow was accidental, suicidal or homicidal. If death was due to a fall, state whether the fall was accidental, suicidal or homicidal. If death was due to a motor vehicle accident, state whether the accident was accidental, suicidal or homicidal. If death was due to a railroad accident, state whether the accident was accidental, suicidal or homicidal. If death was due to a boiler explosion, state whether the explosion was accidental, suicidal or homicidal. If death was due to a fire, state whether the fire was accidental, suicidal or homicidal. If death was due to a collapse, state whether the collapse was accidental, suicidal or homicidal. If death was due to a suffocation, state whether the suffocation was accidental, suicidal or homicidal. If death was due to a starvation, state whether the starvation was accidental, suicidal or homicidal. If death was due to a exposure, state whether the exposure was accidental, suicidal or homicidal. If death was due to a heat stroke, state whether the heat stroke was accidental, suicidal or homicidal. If death was due to a sunstroke, state whether the sunstroke was accidental, suicidal or homicidal. If death was due to a lightning, state whether the lightning was accidental, suicidal or homicidal. If death was due to a electrocution, state whether the electrocution was accidental, suicidal or homicidal. If death was due to a drowning, state whether the drowning was accidental, suicidal or homicidal. If death was due to a hanging, state whether the hanging was accidental, suicidal or homicidal. If death was due to a gunshot wound, state whether the wound was accidental, suicidal or homicidal. If death was due to a stabbing, state whether the stabbing was accidental, suicidal or homicidal. If death was due to a blow, state whether the blow was accidental, suicidal or homicidal. If death was due to a fall, state whether the fall was accidental, suicidal or homicidal. If death was due to a motor vehicle accident, state whether the accident was accidental, suicidal or homicidal. If death was due to a railroad accident, state whether the accident was accidental, suicidal or homicidal. If death was due to a boiler explosion, state whether the explosion was accidental, suicidal or homicidal. If death was due to a fire, state whether the fire was accidental, suicidal or homicidal. If death was due to a collapse, state whether the collapse was accidental, suicidal or homicidal. If death was due to a suffocation, state whether the suffocation was accidental, suicidal or homicidal. If death was due to a starvation, state whether the starvation was accidental, suicidal or homicidal. If death was due to a exposure, state whether the exposure was accidental, suicidal or homicidal. If death was due to a heat stroke, state whether the heat stroke was accidental, suicidal or homicidal. If death was due to a sunstroke, state whether the sunstroke was accidental, suicidal or homicidal. If death was due to a lightning, state whether the lightning was accidental, suicidal or homicidal. If death was due to a electrocution, state whether the electrocution was accidental, suicidal or homicidal.

CAUSE OF DEATH in plain terms. Abbreviations not allowed. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

18567 — 129 E·18567

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2810 N. Calvert St. 12-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anastasia Butler

(a) RESIDENCE NO. 2810 N Calvert St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James J. Butler

6 DATE OF BIRTH (month, day, and year): Feb 10 1853

7 AGE — Years: 73 — Months: 11 — Days: 20 — IF LESS than 1 day ... hrs. or ... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer): 027

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Patrick Corcoran

11 BIRTHPLACE OF FATHER (City or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Bridget Dunn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mollie B. Butler (Address) 2810 N. Calvert St

15 Filed JAN 1 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: January 30, 1927

17 I HEREBY CERTIFY, That I attended deceased from June, 1924, to Jan 30, 1927, that I last saw her alive on Jan 29, 1927, and that death occurred, on the date stated above, at 6.30 a m.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial nephritis

(duration) 5 yrs. mos. da.

CONTRIBUTORY (Secondary) Arterial Hypertension & Hemiplegia

(duration) 3 yrs. mos. da.

18 Where was disease contracted: at Home

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Wm. R. Straight, M. D.

1/31, 1927 (Address) 2225 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — Date of Burial: 2/2/ 1927

20 UNDERTAKER: J. A. Moran — ADDRESS 300 E Baltimore St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18568

## CERTIFICATE OF DEATH.

181-001 E 18568

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital St. 5-6 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Hughes

(a) RESIDENCE NO. 610 N. Eden St St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | white | widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) Mar 9/1852

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 74 | 10 | 21 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER John McGinnis

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Cassidy

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Ireland

14 Informant Anna Philbin

(Address) 311 Highland Ave

15 Filed 1927, 19__ C. HAMPSON JONES, M. D.

By _____ Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 Jan 30/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Enquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Uremia -Chr Nephritis

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Accidental ?arbon Monoxide Poisoning

(duration) ...yrs. ...mos. ...ds.

(Signed) J. H. Bates, M. D.

(Coroner)

2/1/27 19 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the state.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?_____

Former or usual residence_____

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Com Date of Burial 2/2/27

20 UNDERTAKER J. J. Moran ADDRESS 3dg E. Balto

OF DEATH in plain terms, so that it may be properly classified. Exact address of occurrence very important. See instructions on back of certificate.

Spec.—12-9-96 C—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18569 — CERTIFICATE OF DEATH. 101-001 — E 18569

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

City of BALTIMORE: (No. ____ St., 9-46 Ward)

REGISTERED NO. ____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph M. Roberts

(a) RESIDENCE NO 1564 Abbottston St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 8th - 26

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | XXX | 5 | 22 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ____

(State or country) Balto Md.

PARENTS

10 NAME OF FATHER James Roberts

11 BIRTHPLACE OF FATHER (city or town) ____

(State or country) Balto, Md.

12 MAIDEN NAME OF MOTHER Ethel Woodward

13 BIRTHPLACE OF MOTHER (city or town) ____

(State or country) Balto Md.

14 Informant Records

(Address) ____

1927 C. HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 Jan. 30th

17 I HEREBY CERTIFY, That I attended deceased from Jan 28, 1927, to Jan 30, 1927, that I last saw h.. alive on Jan 30, 1927, and that death occurred, on the date stated above, at 8:08 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ____ yrs. ____ mos. 12 ds.

CONTRIBUTORY (Secondary) Otitis Media

(duration) ____ yrs. ____ mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ____

Was there an autopsy? Yes

What test confirmed diagnosis? ____

(Signed) Roger L. Cornwall M. D.

(Address) Johns Hopkins Hospital Jan 31 1927

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery Date of Burial Feb. 2 1927

20 UNDERTAKER Joseph L. Cook ADDRESS 1003 W. Balto St.

OF DEATH in plain terms, so that it may be properly classified. Every item is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18570

## CERTIFICATE OF DEATH.

E 18570

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Pronounced dead at

City of BALTIMORE: (No. Colonial Hospital St., 12-19 Ward)

2-FULL NAME James Tasker Rubie

(a) RESIDENCE NO. 227 E. Lafayette Ave St. _____ Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 59 yrs. ? mos. ? ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Laura E. Rubie

6 DATE OF BIRTH (month, day, and year) about Jan-12-1865

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | about 62 | 0 | 19 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chief Clerk to Div. Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) Penna. R. R. Co.

(c) Name of employer

9 BIRTHPLACE (city or town) Lincolnshire

(State or country) England

PARENTS

10 NAME OF FATHER James Rubie

11 BIRTHPLACE OF FATHER (city or town) not known

(State or country) England

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) not known

(State or country) England

14 Informant Mrs. Laura E. Rubie (wife)

(Address) 227 E. Lafayette Ave.

Filed _____, 19____ C. HAMPSON JONES, M. D. Registrar

1927

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 31, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

cerebral Hemorrhage

(duration) _____ yrs. _____ mos. 1 ds.

CONTRIBUTORY (Secondary) no history

(duration) _____ yrs. _____ mos. _____ ds.

(Signed) D. J. Hennessey M. D. (Coroner)

Feb 4, 1927 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death 0 yrs. 0 mos. 0 ds. In the State 24 yrs. ? mos. ? ds.

Where was disease contracted, if not at place of death? Taken ill Penna - North Ave.

Former or usual residence 227 E. Lafayette Ave

19 PLACE OF BURIAL, CREMATION OR REMOVAL York - Penna Date of Burial Feb 3 1927

20 UNDERTAKER STEPHEN J. MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

OF DEATH in plain terms, so that it may be properly classified. Name of disease alone is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18571 122-002 E 18571

## CERTIFICATE OF DEATH.

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 103 N. Belair Road St. 27-40 Ward)

2-FULL NAME Carrie E. Haebler

(a) RESIDENCE NO. 103 N. Belair Road, St. _____ Ward _____

(Usual place of abode) Lifetime.

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anthony J. Haebler Sr.

6 DATE OF BIRTH (month, day, and year) April 13th. 1854

| 7 AGE Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|
| 72 | 9 | 17 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William Getterman

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Germany.

14 Informant Anthony J. Haebler Sr.

(Address) 103 N. Belair Road.

15 1927 C. HAMPSON JONES, M. D. Registrar

Per _____

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

January 30th. 1927.

17

I HEREBY CERTIFY, That I attended deceased from Jan 5, 1925, to Jan 30, 1927, that I last saw h[illegible] alive on Jan 29, 1927, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Nephritis Chronic

(duration) _____ yrs. 8 mos. _____ ds.

CONTRIBUTORY (Secondary) Cirrhosis of the liver

(duration) 2 yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? No Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? Physical & urin test

(Signed) Chas Frahm, M. D.

2/1, 1927 (Address) 1823 N. Monroe St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Holy Redeemer Cemetery. 2/2 1927.

20 UNDERTAKER — ADDRESS

Chas P. Evans & Son 1184 W. McMahon Ave.

OF DEATH in plain terms, so that it may be properly classified. Items are very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18572

## CERTIFICATE OF DEATH.

179 E 18572

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Md. Gen. Hospital 13

City of BALTIMORE: (No. ~~1038 Ark~~ St., Ward)

2-FULL NAME Arthur Simms

(a) RESIDENCE NO. 1038 N. Dunbar St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | Colored | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gertrude Simms

6 DATE OF BIRTH (month, day, and year) Feb. 27, 1896

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 31 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer Bethlehem Steel Co.

9 BIRTHPLACE (city or town) Va.

(State or country)

PARENTS

10 NAME OF FATHER Tinsley Simms

11 BIRTHPLACE OF FATHER (city or town) Va.

(State or country)

12 MAIDEN NAME OF MOTHER Lucy Lockett

13 BIRTHPLACE OF MOTHER (city or town) Va.

(State or country)

14 Informant Gertrude Simms

(Address) 1038 N. Dunbar St

15 Filed FEB 1927 C. HAMPSON JONES, M. D. Registrar

Rec'd 0016

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 30, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the date stated above.

The CAUSE OF DEATH* was as follows:

3rd. degree burns of body.

accidental (duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Fell into molten steel. (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D. (Coroner)

Feb. 1, 1927 (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Jamsville Va | Feb. 1st 1927 |

| 20 UNDERTAKER | ADDRESS |
|---|---|
| Mrs. R. G. Elliott | 1125 Eastland Ave |

OF DEATH in plain terms, so that it may be properly classified. Each statement of certificate. very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 18573 ✓ 129 E 18573

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospital 11-2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joshua Fisbies

(a) RESIDENCE NO. 925 Monroe St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| M. | Col. | Married |

3a If married, widowed, or divorced HUSBAND of (or) WIFE of ? Unknown

6 DATE OF BIRTH (month, day, and year) Unknown.

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 56 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER Wm J. Fisbies

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Eliza Jane

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Mary Fisbies

(Address) 925 Monroe st

15 Date 1927 C. HANSON JONES, M. D. Registrar

By Asst

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 Jan. 30. 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 28, 1927, to Jan. 30, 1927, that I last saw ~~him~~ alive on Jan. 30, 1927, and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows: Chronic Interstitial [redacted] Nephritis.

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) Cerebritis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? (None)

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Physical Signs.

(Signed) Maywell, M. D.

, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cemtry Date of Burial Feb 1st 1927

20 UNDERTAKER Mrs Ada Saunders ADDRESS 1715 E Madison

OF DEATH in plain terms, so that it may be properly classified. Please write very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18574

## CERTIFICATE OF DEATH

100-001

E 18574

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3004 Hudson St., 1-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth J. Kachuba

(a) RESIDENCE NO. 3004 Hudson St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 3-1924

7 AGE Years 2 Months 2 Days 28 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md

(State or country)

PARENTS

10 NAME OF FATHER Lawrence Kachuba

11 BIRTHPLACE OF FATHER (City or town) Balto Md

(State or country)

12 MAIDEN NAME OF MOTHER Frances Baranaska

13 BIRTHPLACE OF MOTHER (city or town) Balto Md

(State or country)

14 Informant Lawrence Kachuba

(Address) 3004 Hudson St

15 Filed 2-1 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31 19 27

17 I HEREBY CERTIFY, That I attended deceased from 1-21 19 27 to 1-31 19 27

that I last saw h[illegible] alive on 1-30 19 27

and that death occurred, on the date stated above, at 3:00 a.m.

The CAUSE OF DEATH* was as follows:

Ac Bronchitis

Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) [illegible] M. D.

(Address) 3325 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Stanislaus Feb 2 1927

20 UNDERTAKER John M Weber ADDRESS 1803 Eastern Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 18575

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 18575 REGISTERED NO.

1-PLACE OF DEATH Extreme end W 33rd St

City of BALTIMORE: (No. 59 Spring Row St., 13-57 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard T. Myers

(a) RESIDENCE NO. 59 Spring Row St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 6, 1926.

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | | 4 | 26. | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER Robert L. Myers

11 BIRTHPLACE OF FATHER (city or town) Pa

(State or country)

12 MAIDEN NAME OF MOTHER Viola M. Sakers

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Laurel Md

14 Informant Viola M. Myers

(Address) 59 Spring Row

15 Filed FEB 2 1927, 19 HARPER JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 1 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:—

Concussion

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) John J. Morrissey M. D.
Coroner

2/2, 1927 (Address) 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

St Marys Stampden Feb 2 1927

20 UNDERTAKER ADDRESS

Chenoweth Son 3617 Chestnut Ave

OF DEATH in plain terms, so that it may be properly classified. Use no abbreviations or terms of doubtful meaning. Fill out every item for which you have the information. Omit nothing that is known to you to be correct and which is required to complete the certificate. Every certificate must be signed. Every item is very important. See instructions on back of certificate.

FEB 2 1927

Spec.—7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18576

## CERTIFICATE OF DEATH

29

E 18576

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3037 Cedar Ave. St. 13-51 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Fair

(a) RESIDENCE NO. 3037 Cedar Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed.

5a If married, widowed, or divorced (or) WIFE of: Lucian D. Fair

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 71 Months Days

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Md.

(State or country)

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (City or town): Unknown

(State or country)

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Unknown

14 Informant: A. B. Fair

(Address): 3037 Cedar Ave.

Filed FEB - 2 1927

C. HARRISON JONES, M.D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 Feb. 1,

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1926, to Feb. 1, 1927

that I last saw h alive on Feb. 1, 1927

and that death occurred, on the date stated above, at 3 45 a. m.

The CAUSE OF DEATH* was as follows: Uremia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chron. Int. nephritis

(duration) 1? yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Same

Did an operation precede death? No Date of

Was there an autopsy? No Lumbago & Pneumonia

What test confirmed diagnosis?

(Signed) Edward Keedy, M. D.

2/1, 1927 (Address) 4 Somerset Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Marys Hampden

Date of Burial: Feb 3 1927

UNDERTAKER: Chenoweth Dodson

ADDRESS: 3615 Chestnut Ave

Fill in above in ink, in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

Louis S Reed.

E 18577

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

101-001

E 18577

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 3308 Ridgewood Ave. 16-67 Ward)

2-FULL NAME Louis S. Reed

(a) RESIDENCE NO. 3308 Ridgewood Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred from birth yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Caroline Eliz. Reed

6 DATE OF BIRTH (month, day, and year) Aug. 10, 1859

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 67 | 5 | 20 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Jobbing

(c) Name of employer No one

9 BIRTHPLACE (city or town) Md.

(State or country) Suppose Balto Co.

PARENTS

10 NAME OF FATHER Louis

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Sofia Lyons

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Norman Reed

(Address) 2655 Lafayette Ave

15 Filed C. HARTZELL JONES, M. D. Registrar

FEB - 2 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 30, 27 19

17 I HEREBY CERTIFY, That I attended deceased from January 26 1927, to January 30th 1927, that I last saw h[illegible] alive on January 30th 1927, and that death occurred, on the date stated above, at 3:20 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia R. Lower Lobe

Focloving Influenza Arteriosclerosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Hiatus Hernia

12 Yrs

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Auscultation

(Signed) E. E. Smith M. D.

Jan 30 1927 (Address) 1605 N. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem. Date of Burial Feb 2 1927

20 UNDERTAKER Thenowethdon ADDRESS 3615 Elmtont Ave.

OF DEATH in plain terms, so that it may be properly very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 18578

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

38 E 18578

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 705 Y Alley St., 27-31 Ward)

2-FULL NAME Vestilia Johnson

(a) RESIDENCE NO. 705 Y Alley St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Fe | Col | single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 6 1900

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 26 | 6 | 24 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore

PARENTS

10 NAME OF FATHER Daniel Johnson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Alice Corbin

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va.

14 Informant Alice Johnson

(Address) 705 Y Alley

15 Filed FEB 2 1927, 19 HARRY O'L. JONES, M. D. Registrar

By DK

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Jan. 30 '27

17 I HEREBY CERTIFY, That I attended deceased from Jan 18, 1927, to Jan 30, 1927, that I last saw h[illegible] alive on Jan 30, 1927, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis
(Probably Luetic)
(duration) yrs. 10 mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) O. H. Harrell, M. D.

2/1, 192[illegible] (Address) 705 Y Alley

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL, Mt. Zion Ct Date of Burial Feb 19[illegible]

20 UNDERTAKER S. E. Brown & Son ADDRESS 108 W Monument St

OF DEATH in plain terms, so that it may be properly classified. very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 ✓

E 18579

REGISTERED NO. E 18579

PLACE OF DEATH

City of BALTIMORE: (No. 2139 Homewood Av. 9-46 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Powitz

(a) RESIDENCE NO. 2139 Homewood Av. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. 11 mos. 5 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

3a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Craftan Powitz

6 DATE OF BIRTH (month, day, and year) February 26th 1876

| 7 AGE Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|
| 50 | 11 | 5 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Master Painter

(b) General nature of industry, business, or establishment in which employed (or employer) House & Sign

(c) Name of employer

9 BIRTHPLACE (city or town) .....

(State or country) Baltimore

PARENTS

10 NAME OF FATHER J. Arcadius Powitz

11 BIRTHPLACE OF FATHER (city or town) .....

(State or country) Riga Russia

12 MAIDEN NAME OF MOTHER Annie E. Williams

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) Baltimore

14 Informant Mrs. C. Holmes

(Address) Wade Ave Catonsville

JAN 2 1927 19.. C. HARRISON JONES, M. D. Registrar

By J.K

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 31st 1927

17

I HEREBY CERTIFY, That I attended deceased from October 10th 1926, to January 31st, 1927, that I last saw him alive on January 31st, 1927, and that death occurred, on the date stated above, at 12:30 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

7 (duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Tuberculosis Laryngitis

(duration) ..... yrs. 3 mos. 21 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) H. J. Saunders, M. D.

Jan 3, 1927 (Address) 719 E. Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| London Park Cemetery | 2/3 1927 |

20 UNDERTAKER Henry W. Means & Son ADDRESS 1052 W. Saratoga St

OF DEATH in plain terms, so that it may be properly very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001 ✓

E 18580
1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

REGISTERED NO. E 18580

City of BALTIMORE; (No. Johns Hopkins Hospital. St. 2-4 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Baby Mahoney

(a) RESIDENCE NO. 224 S. Castle St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): ~~Married~~, Widowed, or divorced

HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan. 30, 1927

7 AGE — Years: × Months: × Days: × IF LESS than 1 day 2 hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ND

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Md.

(State or country)

PARENTS

10 NAME OF FATHER: Charles V. Mahoney

11 BIRTHPLACE OF FATHER (city or town): England.

(State or country)

12 MAIDEN NAME OF MOTHER: Rose Longworth

13 BIRTHPLACE OF MOTHER (city or town): Md.

(State or country)

14 Informant: J. R. Hoerner MD

(Address) Johns Hopkins Hospital.

15 Filed FEB 2 1927 19 C. HARRISON JONES, M. D.

By ..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 30 19 27

17 I HEREBY CERTIFY, That I attended deceased from Jan. 30, 1927, to Jan. 30, 1927,

that I last saw h.... alive on Jan. 30, 1927,

and that death occurred, on the date stated above, at 1:50 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Placenta Previa

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) J. R. Hoerner, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

JOHNS HOPKINS HOSPITAL

UNDERTAKER — ADDRESS

JOHNS HOPKINS HOSPITAL

OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.
very important.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18581

## CERTIFICATE OF DEATH.

101-001 E 18581

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1105 N. Asquith ST. 10-14 WARD)

2-FULL NAME Annie Marie Kerr

(a) RESIDENCE NO. 1105 N. Asquith ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ~~7~~ mos. ~~17~~ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Thomas Kerr

6 DATE OF BIRTH (month, day, and year) June 15, 1856

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs. or ....min. |
|---|---|---|---|---|
| | 70 | 7 | 16 17 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Catonsville Md.

PARENTS

10 NAME OF FATHER August Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sophia Semma

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Wm. M. Murphy
(Address) 2413 Edgewood Rd

15 Filed FEB 2 1927 C. HARRY JONES, M. D. Registrar
By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 1st 1927

17

I HEREBY CERTIFY, That I attended deceased from aug 15, 1923 to ~~Feb 1~~ Feb 1, 1927.

that I last saw her alive on Feb 1, 1927.

and that death occurred, on the date stated above, at 8.15 a. m.

The CAUSE OF DEATH* was as follows:

Cardio-Renal Disease

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Labor Pneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Lyman V. Abbott, M. D.

, 19 (Address) 1932 A. Coradine

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL Feby 5th 1927

20 UNDERTAKER George Schulling & Sons

ADDRESS 1126 E Monument

CAUSE OF DEATH must be stated plainly. Use no abbreviations or symbols. Do not state mode of dying, such as heart failure, asphyxia, etc., but what caused it. See instructions on back of certificates. TION is very important.

B - 2

Spec.—12-9-8—CO.—200 Bks.

E 18582

# HEALTH DEPARTMENT—CITY OF BALTIMORE

71-001

E 18582

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

City of BALTIMORE: (No. _____ St. 22-31 Ward)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harrison T. Brown

(a) RESIDENCE NO. 5 W. Montgomery St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. — mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1-28-26

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 1 | 0 | 3 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9 BIRTHPLACE (city or town).....

(State or country) Md -

PARENTS

10 NAME OF FATHER Guilford Harrison

11 BIRTHPLACE OF FATHER (city or town).....

(State or country) Va.

12 MAIDEN NAME OF MOTHER Hadys R. Pinell

13 BIRTHPLACE OF MOTHER (city or town).....

(State or country) N. C.

14 Informant Records.

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 2 1927 [illegible] Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 Jan 31

17

I HEREBY CERTIFY, That I attended deceased from Dec. 23, 1926, to Jan 31, 1927, that I last saw him alive on Jan. 31, 1927, and that death occurred, on the date stated above, at 12.00 a.m.

The CAUSE OF DEATH* was as follows:

Pneumococcus Meningitis

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) Hydrocephalus

(duration) yrs. 1½ mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? autopsy

(Signed) W. E. Handley, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery — Date of Burial Feb 2 1927

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

OF DEATH in plain terms, so that it may be very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18583

## CERTIFICATE OF DEATH.

90

E 18583
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1406 N. Mount ST. 15-21 WARD)

2-FULL NAME Willie Johnson

(a) RESIDENCE NO. 1406 N. Mount ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: Colored
5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 7, 1860

7 AGE — Years: 67 — Months: 9 — Days: 23 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Front Royal, Va.

PARENTS

10 NAME OF FATHER: Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not known

12 MAIDEN NAME OF MOTHER: Martha Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Levi Johnson
(Address) 1406 N. Mound St

15 Filed [illegible] 19 C. HAMPSON JONES, M. D. Registrar.

B - 21021

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-30-1927

17 I HEREBY CERTIFY, That I attended deceased from 1-30, 1927, to 1-30, 1927, that I last saw h[illegible] alive on Jan 30, 1927, and that death occurred, on the date stated above, at 9.10 p. m.

The CAUSE OF DEATH* was as follows:

C. Arterio-sclerosis (duration) 6 yrs. mos ds.

CONTRIBUTORY (Secondary) C. myocarditis (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs & symptoms

(Signed) John G. S. Campbell M. D.

19 (Address) 1405 N. Mount

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery

DATE OF BURIAL: Feb 2 1927

20 UNDERTAKER: Wm Sad H. Dennis per T. E. Kelsar

ADDRESS: 1303 Preston

TION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18584
1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

90 E 18584
REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1616 Fauklen ST. 19-27 WARD)

2-FULL NAME Annie E Johnson

(a) RESIDENCE NO. 1616 W. Fauklen ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Colored | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joshua Johnson

6 DATE OF BIRTH (month, day, and year) 1856 — —

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs. or ....min. |
|---|---|---|---|---|
| | 70 | — | — | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Washington
(State or country) D.C.

PARENTS
10 NAME OF FATHER unknown
11 BIRTHPLACE OF FATHER (city or town) unknown
(State or country)
12 MAIDEN NAME OF MOTHER unknown
13 BIRTHPLACE OF MOTHER (city or town) unknown
(State or country)

14 Informant Mrs Estelle Cole
(Address) 1616 Fauklen

15 Filed B - 2 1927, 19 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30 th 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 29 th, 1927, to Jan 30 th, 1927.
that I last saw her alive on Jan 30 th, 1927
and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart
1 hour
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Senility
(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) Dr E Bell M. D.
, 19 (Address) 713 Gilmor

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Laurel Cemetery | 2/2/27 |

20 UNDERTAKER Mrs. R. G. Elliott
ADDRESS 1225 Ashland

CAUSE OF DEATH must be given. Physician's or Coroner's certificate required. See reverse side for additional information.
TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18585

## CERTIFICATE OF DEATH.

32

REGISTERED NO. E 18585

1-PLACE OF DEATH

City of BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL St., 11-24 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Barnes -

(a) RESIDENCE NO. 736 N Entaw St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 2-18-1920.

7 AGE: Years 6 | Months 11 | Days 12 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Md -

PARENTS

10 NAME OF FATHER Benj. Barnes.

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Md.

12 MAIDEN NAME OF MOTHER Virgie Pen Ruby

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) D C.

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

Filed 1927 C. HAMPTON JONES M.D.

FEB-2 1927 Registrar

OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 Jan 30

17

I HEREBY CERTIFY, That I attended deceased from Jan 20, 1927, to Jan 30, 1927, that I last saw h[illegible] alive on Jan 30, 1927, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Meningitis

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Histological Exam

(Signed) Thomas W Compton M. D.

, 19 Address Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, State (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvary Cy Date of Burial Feb 2 1927

20 UNDERTAKER: Leonard Whalen ADDRESS 1017 Myrtle Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

Deisinger

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18586

## CERTIFICATE OF DEATH.

100-001

E 18586

1-PLACE OF DEATH

City of BALTIMORE: (No. 1448 Cookson St., 24-35 Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Deisinger

(a) Residence No. 1448 Cookson St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed or Divorced (Write the word.): Widower

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Catherine Deis

6-DATE OF BIRTH (month, day and year): July 20 1848

7-AGE: 78 yrs. 6 mos. 11 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Germany

PARENTS.

10-NAME OF FATHER: George Germany

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Catherine Deis

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

11- (Informant) Mr George Deisinger

(Address) 1448 Cookson St

15- Filed ... 19... Registrar.

FEB-2 1927 C. HAMPSON JONES, M. D.

Per PH

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Jan 31/27.

17- I HEREBY CERTIFY, That I attended deceased from 1-25-, 1927 to 1-31-, 1927

That I last saw him alive on 1-31-, 1927

and that death occurred, on the date stated above, at 4.10 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary): Edema of both Lungs

(Duration) yrs. mos. 2 ds

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) L. Ford M. D.

2-1, 1927 (Address) 720 N. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross

DATE OF BURIAL: Feb 3 1927

20-UNDERTAKER: Hall & Sons

ADDRESS: 1701 Pennsylvania Ave

Instructions on back of certificate.

Spec.—1-25—A Co.—200 Pks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 18587 (1966) 40

REGISTERED NO. E 18587

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 1351 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leona Matthews

(a) RESIDENCE NO. 2955 Cedar Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb. 5 - 1908

7 AGE: 18 Years 19 | Months 11 | Days 26 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Factory work

(b) General nature of industry, business, or establishment in which employed (or employer): N.H.

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Md -

PARENTS

10 NAME OF FATHER: Frank Matthews

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Md -

12 MAIDEN NAME OF MOTHER: Julia Crouch

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md -

14 Informant: Records -

(Address): JOHNS HOPKINS HOSPITAL

Filed FEB - 2 1927 HARRY JONES, M.D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 1st 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan. 27, 1927, to Feb. 1st, 1927, that I last saw h.r. alive on Feb 1st, 1927, and that death occurred, on the date stated above, at 1.45 PM m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolus?

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Infection Primary Rt. arm

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Y Date of Jan 28th

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A R Thomas Jr., M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill

Date of Burial: Feb 4 1927

20 UNDERTAKER: Chas. L. Stevens

ADDRESS: 1501 Pont Ave.

OF DEATH in plain terms, so that it may be very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18588

## CERTIFICATE OF DEATH.

E 18588

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2820 Boarman ave ST., 15-63 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Etta Meister

(a) RESIDENCE NO. 2820 Boarman ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | W | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Meister

6 DATE OF BIRTH (month, day, and year) Lithuania

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 36 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Moses Meister

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Samuel Meister

(Address) 2820 Boarman ave

15 Filed FEB 2 1927 C. HARRISON JONES, M. D. Registrar

By R.M.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/2 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 27, 1927, to Feb 2 1927, that I last saw her alive on Feb 1 1927 and that death occurred, on the date stated above, at 1:45 a m

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Positive Sputum

(Signed) Jacob Cohen, M. D.

2/2, 1927 (Address) 2230 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Hebrew Rosedale | 2/2 1927 |
| 20 UNDERTAKER | ADDRESS |
| Jack Lewis | 1439 E Baltimore |

TION IS very important

E 18589 Spec. Print. A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

90 ✓

REGISTERED NO. E 18589

1-PLACE OF DEATH

City of BALTIMORE: (No. 1423 Hanover St. 23-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline R. Schmidt

(a) RESIDENCE NO. 1423 Hanover St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. 7 mos. 29 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry H. Schmidt

6 DATE OF BIRTH (month, day, and year): June 2, 1873

7 AGE — Years: 53 — Months: 7 — Days: 29 — IF LESS than 1 day ... hrs. or ... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md.

PARENTS

10 NAME OF FATHER: George Kolz.

11 BIRTHPLACE OF FATHER (City or town): Germany

(State or country)

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md.

14 Informant (Address): Mr. Henry H. Schmidt Sr. 1423 Hanover St.

Filed FEB - 2 1927 C. HARRISON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 1 19 27

17 I HEREBY CERTIFY, That I attended deceased from Jan 4 to Feb 1 19 27.

that I last saw her alive on Feb 1 1930 27.

and that death occurred, on the date stated above, at 7 30 P.M.

The CAUSE OF DEATH* was as follows:

Acute Cardiac dilatation

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Mitral Insufficiency

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John C. Schmidt M. D.

. 19 (Address) 1337 E. Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. Date of Burial: Feb. 3 1927

UNDERTAKER: Wm. Fickenscher Sons ADDRESS: North Ave

OF DEATH in plain terms, so that it may be properly classified. Every statement must be full and very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18590

## CERTIFICATE OF DEATH

90

E 18590

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No.) 2413 Edmondson Ave. St. 20-69 Ward 1

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christian Julius Smith Jr.

(a) RESIDENCE NO. 2413 Edmondson Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. 0 mos. 15 ds. (If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alberta Ryan Smith

6 DATE OF BIRTH (month, day, and year) Jan. 16, 1868

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..hrs. or ..min.. |
|---|---|---|---|---|
| | 59 | 0 | 15 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Travelling Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 066

(c) Name of employer Largent & Co.

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER Christian Smith Sr.

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Weinberg

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs Alberta R. Smith

(Address) 2413 Edmondson Ave.

15 Filed 2 1927 C. HARRY JONES, M. D., Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 1 19 27

17 I HEREBY CERTIFY, That I attended deceased from Jan 29, 1927, to Feb. 1, 1927, that I last saw him alive on Jan 31, 1927, and that death occurred, on the date stated above, at 7.30 A.m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. few hours mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M Bernard Kool, M. D.

2/2, 1927 (Address) 626 N. Johnson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Philadelphia Pa | Feb. 3 1927 |

20 UNDERTAKER Wm Tucker & Sons ADDRESS North Pa

OF DEATH in plain terms, so that it may be properly classified. State disease, if any, which caused death, as well as the primary cause, if known. Do not use abbreviations or terms of doubtful meaning. Be sure that your answers to questions are full, complete and accurate, and that they are written in ink. Please write very plainly. Cause of death must be certified to the best knowledge and belief of the physician, coroner or other official who has investigated the case. Certificates must be made out and signed in accordance with the law and instructions of the Health Department. See instructions on back of certificates.

B 2 1927

Spec.-7-17-26—A Co.—200 Bks.

E 18591

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

71-001

E 18591

REGISTERED NO.

1-PLACE OF DEATH St Agnes Hospital

City of BALTIMORE: (No. 14-10 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Lipp

(a) RESIDENCE NO. St Vincents Infant asylum St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S. if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3/12 1924

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 2yrs | 10 | 19 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER not known

11 BIRTHPLACE OF FATHER (City or town)

(State or country) not known

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) not known

14 Informant St Vincent Inf Asy

(Address) Division & Mosher

Filed FEB - 2 1927

C. HAMPSON JONES M. D. Registrar

By R.H.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 27

Feb 1 8.40 a. m.

17 I HEREBY CERTIFY, That I attended deceased from Jan 27, 1927, to Feb 1, 1927, that I last saw h[illegible] alive on Feb 1, 1927, and that death occurred, on the date stated above, at 8.40 A m.

The CAUSE OF DEATH* was as follows:

Pneumococcic Meningitis

(duration) 6 yrs. 0 mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Gross findings

What test confirmed diagnosis?

(Signed) A P McBride, M. D.

, 19 (Address) 4 Cyprus Apts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem Date of Burial 2/2 19 27

20 UNDERTAKER George J Ruth ADDRESS 1730 Hartford Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statements are very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

# E 18592 HEALTH DEPARTMENT—CITY OF BALTIMORE E 18592

## CERTIFICATE OF DEATH.

X 46

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1604 Druid Hill Ave St. 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Emily Hebron.

(a) Residence No. Prince Georges Co Md St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored,

5-Single, Married, Widowed, or Divorced, (Write the word.) widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Widow of John Hebron

6-DATE OF BIRTH (month, day and year) 68 (about)

7-AGE, 68 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housework

(b) General nature of industry, business, or establishment in which employed (or employer). Private 070

(c) Name of employer. Humphry Hunt

9-BIRTHPLACE (city or town) (State or Country), Prince Georges County Maryland

PARENTS.

10-NAME OF FATHER, Benjamin Cornell

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Prince Georges Co Maryland

12-MAIDEN NAME OF MOTHER, Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Prince Georges Co Maryland

14- (Informant) Pearl H. Williams

(Address) 1604 Druid Hill Ave

Filed FEB. 2 1927 HARRY H. JONES, M. D. 192

Registrar

Per

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 13th 1927

17- I HEREBY CERTIFY, That I attended deceased from January 27 1927 to Feb 13th 1927

that I last saw her alive on Feb 13th 1927

and that death occurred, on the date stated above, at 10.45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus and Asthenia

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Prince Geo. Co. Md.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) J. Bunnell Tapp M. D.

, 19 (Address) 2932 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Ft Lincoln

DATE OF BURIAL, Feb 14 1927

20-UNDERTAKER, James E. Boyle

ADDRESS 654 Park

instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

74-001

E 18593
REGISTERED NO.

E 18593
1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hosp St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Tillie Schiff

(a) RESIDENCE NO. Altamont Hotel St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of August Schiff

6 DATE OF BIRTH (month, day, and year) About 1856.

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 71 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Simon Pels

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Tata Koopman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Sidney Schiff

(Address) 2353 Eutaw Place

15 Filed FEB 2 1927 19 C. HAMPTON JONES, M. D., Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 2nd 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 28 1927 to Feb 2 1927

that I last saw h[illegible] alive on Feb 2 1927

and that death occurred, on the date stated above, at 7.45 a m.

The CAUSE OF DEATH* was as follows: Intracranial hemorrhage

& cerebral softening

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) ABP - arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? coma - T.P.

(Signed) [illegible] M. D.

. 19 (Address)

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Hebrew Cem. Date of Burial 2/4/1927

20 UNDERTAKER David Sondheim ADDRESS 115-120 W 21st. Royal Pl.

FEB - 2 1927

OF DEATH in plain terms, so that it may be very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks. {ANASTASIOS PROFERES}

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18594

CERTIFICATE OF DEATH.

131 E 18594

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL St. 4-7 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anastasios Profiles Aroferes

(a) RESIDENCE NO. 621 E. Fayette St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chrisula Proferes

6 DATE OF BIRTH (month, day, and year) 1847

| 7 AGE Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|
| 80 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Vendor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) Greece

PARENTS

10 NAME OF FATHER James Profiles

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Greece

12 MAIDEN NAME OF MOTHER Mary Drougas

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Greece

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 2 1927 19 C. HARTOG (JOHNS HOPKINS HOSPITAL) Registrar

By RRR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 31 19 27

17

I HEREBY CERTIFY, That I attended deceased from Jan. 7, 1927, to Jan. 31, 1927, that I last saw h alive on Jan. 31, 1927, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial failure

Broncho-pneumonia

Pyelonephritis.

(duration) 8 yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Uremia; arteriosclerosis

(duration) unkn yrs. mos. ds.

18 Where was disease contracted? ?

If not at place of death?

Did an operation precede death? Prostatectomy Yes Date of Jan. 21, 1927

Was there an autopsy? No

What test confirmed diagnosis? Electrocardiogram

(Signed) F W. Schacht, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn cem Date of Burial Feb 3 1927

20 UNDERTAKER John McWeber ADDRESS 1803 Bank St

OF DEATH in plain terms, so that no abbreviation, guess, or technical term may be used. Every question must be answered, or the words "unknown" or "none" inserted, as the case may be. Omissions will cause unnecessary correspondence and delay. Certificates. very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

E 18595

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 18595

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS 37

City of BALTIMORE: (No. [redacted] St. 16 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Schroeder

(a) RESIDENCE NO. BALTIMORE CITY HOSPITALS St. ____ Ward ____

(Usual place [redacted] (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | ? |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1861

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 66 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

FEB 2 1927 C. HAMPSON JONES, M. D.

1003 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 29 1927

17

I HEREBY CERTIFY, That I attended deceased from December 25, 1926, to January 29, 1927, that I last saw h[redacted] alive on January 29, 1927, and that death occurred, on the date stated above, at 1.30 p m.

The CAUSE OF DEATH* was as follows:

Senility

Cerebral Sclerosis

0

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ___ yrs. ___ mos. 3 ds.

18 Where was disease contracted

If not at place of death!

Did an operation precede death! no Date of

Was there an autopsy? no

What test confirmed diagnosis? general & laboratory

(Signed) E. D. Hooper Lunt M. D.

Feb 2 1927 (Address) BALTIMORE CITY HOSPITALS

[redacted]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

Commissioner Health. FEB 2 1927

OF DEATH In plain terms, so that it may be readily understood. Use no abbreviations. Punctuation is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18596

100-001

E 18596

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. ____ St., 76-37 Ward)

REGISTERED NO. ____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Williams

(a) RESIDENCE NO. ____ St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | Negro | Widowed |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1841

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 86 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ____

(State or country) Virginia

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ____

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ____

(State or country) ?

14 Informant ____

(Address) Records

15 Filed ____ C. HAMPSON JONES, M. D. Registrar.

Per ____ 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 31 1927

17

I HEREBY CERTIFY, That I attended deceased from August 20, 1925, to January 31, 1927, that I last saw h. alive on January 30, 1927, and that death occurred, on the date stated above, at 1 30 A m.

The CAUSE OF DEATH* was as follows:

Senility

Cerebral Sclerosis

(duration) ? yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ____ yrs. ____ mos. 3 ds.

18 Where was disease contracted

If not at place of death? ____

Did an operation precede death? no Date of ____

Was there an autopsy? no

What test confirmed diagnosis? general & Laboratory

(Signed) W. Hooper Lull M. D.

Feb 2 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ____ Date of Burial ____ 19

20 UNDERTAKER ____ ADDRESS ____

JOHNS HOPKINS HOSPITAL

Commissioner Health.

FEB 4 1927

OF DEATH in plain terms, so that they may be understood. Items are very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18597

## CERTIFICATE OF DEATH.

161-001

E 18597

1-PLACE OF DEATH

City of BALTIMORE: (No. 1416 W. Fayette St. 19-27 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Caperon

(a) RESIDENCE NO. 1416 W Fayette St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| M | W | Sgle |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1/24/27

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | | | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balt

(State or country)

PARENTS

10 NAME OF FATHER Geo. H. Caperon

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto.

12 MAIDEN NAME OF MOTHER Cora Harmon

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto

14 Informant

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D.
Registrar

FEB 2 1927

100

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/30/27 19

17

I HEREBY CERTIFY, That I attended deceased from 1/24/27 19 ..... to 1/30/27 19 .....,

that I last saw h... alive on 1/30/27 19 .....,

and that death occurred, on the date stated above, at 12 30 p. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(Premature 6 Mo.)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY —

(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? — Date of .....

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Bernard J. Feeny, M. D.

2/1/ 1927 (Address) 910 W Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

JOHNS HOPKINS HOSPITAL FEB 2 1927

Commissioner of Health

OF DEATH in plain terms, so that it may be of very important. See instructions on back of certificat

Cor.—1-12-23—M&T—100 Bks.

E 18598

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18598

## CERTIFICATE OF DEATH.

REGISTERED NO. 66

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 815 E Pratt ST., 3-5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Unknown.

(a) RESIDENCE NO. 815 E Pratt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | White | |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1852

| 7 AGE Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|
| 45 | | | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work 087
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant
(Address)

15 Filed Jan 27 192 C. HAMPSON JONES, M. D. Registrar

FEB 2 1927

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Alcoholism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

Feb 27 Geo. Claston Blades M. D.

~~Deceased~~ (Coroner) (Address) 743 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL. JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 192

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact name of disease, not mode of dying, must be given. Indefinite statements, such as "Heart Failure," "Exhaustion," "Old Age," "Cancer," "Tumor," "Abscess," "Child-bed," "Accident," "Fracture," "Drowning," "Burns," "Hemorrhage," "Convulsions," "Fever," "Debility," "Dropsy," "Jaundice," "Stillborn," "Premature Birth," "Cholera Morbus," "Cholera Infantum," "Inanition," "Marasmus," "Lockjaw," "Gangrene," "Blood Poisoning," "Peritonitis," "Meningitis," "Childbirth," "Puerperal Fever," "Puerperal Convulsions," "Puerperal Septicemia," "Puerperal Hemorrhage," "Puerperal Abscess," "Puerperal Peritonitis," "Puerperal Meningitis," "Puerperal Eclamps

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18599

## CERTIFICATE OF DEATH.

22-3 | 101-08

E 18599

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 127 W. Hill St. St., _____ Ward)

2-FULL NAME John Lewis.(C)

(a) RESIDENCE NO. 127 W. Hill St. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male. | Colored | Single. |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) Do not know.

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 45 | --- | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 0 0

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia.

PARENTS

10 NAME OF FATHER Peter Lewis.(C)

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Do not know.

14 Informant Minnie Lewis.(C) sister.

(Address) 810 Peach Alley.

15 Filed ..... 19 ..... G. HAMPSON JONES M. D. Registrar

FEB - 7 1927

0999 THE MORGUE.

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 20. 1927. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) duration .....yrs. .....mos. .....ds.

(Signed) Otto Bernhardt M. D.
(Coroner)

2/1 . 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL Date of Burial 19

20 UNDERTAKER ADDRESS

FEB 2 - 1927

OF DEATH in plain terms, so that it may be very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 18600

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18600

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1546 Argyle ST. 14-20 WARD)

REGISTERED NO. 161

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Jackson

(a) RESIDENCE NO. 1546 Argyle ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| m | c | S |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1-31-27

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | | | 2 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Andrew Jackson

11 BIRTHPLACE OF FATHER (city or town) Providence R.I.
(State or country)

12 MAIDEN NAME OF MOTHER Helen Esther Perry

13 BIRTHPLACE OF MOTHER (city or town) Jacksonville
(State or country) Fla.

14 Informant mother
(Address)

15 Filed ... 19 HAMPSON JONES, M. D.
Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-2 1927

17 I HEREBY CERTIFY, That I attended deceased from 1-31, 1927, to 2-2, 1927, that I last saw h— alive on 2-2, 1927, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) malnutrition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. d. Berry, M. D.

19 (Address) 1520 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

JOHNS HOPKINS HOSPITAL

Commissioner of Health

FEB 4 1927

FEB 2 1927

LOUIS R. RUTH

Spec.—1-12-23—M&T—500 Bks.

18601

# HEALTH DEPARTMENT—CITY OF BALTIMORE E 18601

## CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH 4604 Belview Ave. REGISTERED NO. 28-63

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ) ST. WARD

2-FULL NAME EDWARD HUPFER

(a) RESIDENCE No. 4604 Belview Ave, ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? Life mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W

5 Single, Married, Widowed or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary A Stewart

6 DATE OF BIRTH (month, day, and year): Feb. 2-1894

7 AGE: Years 32 | Months 11 | Days 29 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer): M & M-T-Co.

(c) Name of employer: Same.

9 BIRTHPLACE (city or town) (State or country): Baltimore. Md.

PARENTS

10 NAME OF FATHER: Benedict Hupfer.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Emelia Hannemann

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: MARY A HUPFER (Address)

15 2 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 31 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 29, 1927 to Jan 31, 1927.

that I last saw him alive on Jan 31, 1927.

and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia Type 2

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) R. C. Smith, M. D.

1927 (Address) 4504 Belview Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: 2-2-1927.

20 UNDERTAKER: Martin Fahey & Son — ADDRESS: 1867 W North Ave.

Spec.—1-10-21—M&T—1500 Bks.

E 18602

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18602

## CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Saint Vincent Infant Asylum ST. W-20 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jane Leery (Sister Veronica)

(a) RESIDENCE No. St Vincent Infant Asylum ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Correct Name

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| About 70 | | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

068

9 BIRTHPLACE (city or town) (State or country) Meriden Conn.

PARENTS

10 NAME OF FATHER John Leery

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Sister Catherine (Address) 1401 Division St

15 AUG - 2 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 1927

17 I HEREBY CERTIFY, That I attended deceased from July 26 1927 to July 1 1927

that I last saw h[illegible] alive on July 1 1927

and that death occurred, on the date stated above, at 5 20 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Chr Myocarditis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Chas T Chandler M. D.

July 2 1927 (Address) 1504 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Catholic Cemetery

DATE OF BURIAL 8-4 1927

20 UNDERTAKER Martin Fahey & Son

ADDRESS 2248 North Ave.

GROUP OF DISEASES. TION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18603 ✓ 1927 E 18603

## CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 7-9 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Roy H. White

(a) RESIDENCE NO. 115 Springfield Av. Norfolk Va Ward Norfolk Va.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 24 How long in U. S., if of foreign birth? 37 yrs. 6 mos. 4 ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Blanche E. White

6 DATE OF BIRTH (month, day, and year) July-28-1889

| 7 AGE Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|
| 37 | 6 | 4 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Auto Dealer

(b) General nature of industry, business, or establishment in which employed (or employer) Automobiles

(c) Name of employer Self 045

9 BIRTHPLACE (city or town) .....

(State or country) ~~Va~~ Michigan

PARENTS

10 NAME OF FATHER Herbert White

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Bessie Decker

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Records (Mrs Blanche E. White (wife) Norfolk Va.
(Address) JOHNS HOPKINS HOSP.

15 Filed 2 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 1 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 8, 1927, to Feb 1, 1927, that I last saw h[illegible] alive on Feb. 1, 1927, and that death occurred, on the date stated above, at 11:30P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) ? yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Uremia

(duration) ..... yrs. ..... mos. 10 ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Laboratory

(Signed) W. Lindsay Miller, M. D.

2/2/1927 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL Norfolk Va Date of Burial Feb 2 1927

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

OF DEATH in pencil, very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

(Davies)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 9 T8604

CERTIFICATE OF DEATH.

x 49 E 18604

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 14 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hugh R. Davies

(a) RESIDENCE NO. Clarks Summit St. Pa Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 18 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of May M. Davies

6 DATE OF BIRTH (month, day and year) May 13 1874

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 52 | 8 | 19 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Pa

(State or country)

PARENTS

10 NAME OF FATHER John Davies

11 BIRTHPLACE OF FATHER (city or town) Wales

(State or country)

12 MAIDEN NAME OF MOTHER Mary Hughes

13 BIRTHPLACE OF MOTHER (city or town) Pa.

(State or country)

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

2 1927 C. HUMPSON JONES, M. D.

Registrar

Mrs. Hugh R. Davies

Clarks Summit Pa

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 2 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 15 1927, to Feb. 2 1927, that I last saw him alive on Feb. 2 1927, and that death occurred, on the date stated above, at 2:30 P m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Ischium

(duration) yrs. 15 mos. ds. (History)

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R. Lindsay Mills, M. D.

2/2/1927 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Scranton. Pa Date of Burial Feb. 2 1927

20 UNDERTAKER Wm J. Tuckerton & Son ADDRESS N. V Pa

- OF DEATH in plain words, very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18605

## CERTIFICATE OF DEATH.

x 129 E 18605

1-PLACE OF DEATH South Baltimore General Hospital REGISTERED NO.

City of BALTIMORE: (No. 1211 S. Light St. 24-23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Ettie Chaney

(a) RESIDENCE NO. Odenton, Md. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J. Milton Chaney

6 DATE OF BIRTH (month, day, and year) Aug. 27, 1884

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 42 | 5 | 5 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Indastry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Savage, Md.

PARENTS

10 NAME OF FATHER Wm. H. Purcell

11 BIRTHPLACE OF FATHER (city or town) Laurel

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Sophie Pallmer

13 BIRTHPLACE OF MOTHER (city or town) Brooklyn

(State or country) Maryland

14 Informant J. Milton Chaney

(Address) Odenton, Md

FEB 3 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 1, 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1927, to Feb 1, 1927, that I last saw h.. alive on Feb 1, 1927, and that death occurred, on the date stated above, at 2:00 m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Chronic nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. E. Miller, M. D.

Feb 19 27 (Address) 1211 S. Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Odenton, Md. Date of Burial Feb. 3 1927

20 UNDERTAKER Joseph B Cook ADDRESS 1003 W Baltimore St

OF DEATH in plain English, very important. See instructions on back of certificates.

8-2 1927

Spec.—1-12-23—M&T—500 Bks.

E 18606

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18606

## CERTIFICATE OF DEATH.

70

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2216 Boston ST. 1-3 WARD)

2-FULL NAME Dorthey Strzegowski

(a) RESIDENCE NO. 2216 Boston ST., ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | W | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 14 1920

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 6 | 1 | 17 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Strzegowski

11 BIRTHPLACE OF FATHER (city or town) Poland (State or country)

12 MAIDEN NAME OF MOTHER Anna Szczegowska

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Anna Szczegowska
(Address) 2216 Boston St

15 2 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/1 1927

17 I HEREBY CERTIFY, That I attended deceased from 1/10, 1925, to 2/1, 1927.

that I last saw h[illegible] alive on 1/30/27, 1927.

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

One Pulmonary tuberculosis (1925)
Encephalitis
(duration) 2nd yrs. mos ds.

CONTRIBUTORY (Secondary) ..... (duration) ... yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ... Date of

Was there an autopsy? no

What test confirmed diagnosis? Myco Dx

(Signed) Harold Dixon, M. D.

(Address) 3326 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem. DATE OF BURIAL Feb 3 1927

20 UNDERTAKER Kendall Dispolerton ADDRESS 37 E Lanvale

TION IS very important

Spec.—1-10-21—M&T—1500 Blks.

E 18607 HEALTH DEPARTMENT—CITY OF BALTIMORE E 18607

## CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 425 N. Population ST. 18-16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Henry A. Young

(a) RESIDENCE NO. 425 N. Population ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Col. | married |

5a If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Annie F. Young

6 DATE OF BIRTH (month, day, and year) not known

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs. or ....min. |
|---|---|---|---|---|
| | 56 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer O&D

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Levi Young

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Lucy ——

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Annie F. Young

(Address) 425 N. Population St.

15 2 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby. 2 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov. 3, 1926, to Feb. 2, 1927, that I last saw him alive on 1/1, 1927, and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthma (chronic myocarditis - asthma

(duration) yrs. 6 mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs & symptoms

(Signed) J. T. O'Donnell, M. D.

Feb. 2, 1927 (Address) 3310 Tioga Parkway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Mt. Auburn Cem. | 2-5 1927 |
| 20 UNDERTAKER George T. A. Gibson | ADDRESS 1735 Druid Hill Ave |

TION is very important. See instructions on back of certificate.

E 18608

# HEALTH DEPARTMENT—CITY OF BALTIMORE E 18608

## CERTIFICATE OF DEATH.

REGISTERED NO. 28-54/23

1-PLACE OF DEATH.

CITY OF BALTIMORE: (No. 4705 Liberty Hgts ~~Ave~~ WARD 28)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Geisz

(a) RESIDENCE. NO. 4706 Liberty Hgts Aust., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Carrie K Geisz

6 DATE OF BIRTH (month, day, and year): Jan. 4, 1859

7 AGE: Years 68 Months 0 Days 27 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Post Office

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John Geisz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Amelia Hayfe

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Carrie K Geisz
(Address) 4706 Liberty Heights Ave

15 FEB 2 1927 C. HAMPSON JONES, M.D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 1 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 31 1927 to Feb 1 1927, that I last saw him alive on Jan 31 1927, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic Cystitis & Gallstones

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) A. C. Swanke, M. D.

(Address) 4509 Liberty Hgts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemt

DATE OF BURIAL: July 3 1927

20 UNDERTAKER: William Cal

ADDRESS: 502 E Hall St

TION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18609

## CERTIFICATE OF DEATH.

74-001

E 18609

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2808 Walbrook Ave St., 15-68 Ward)

2-FULL NAME Renatus C. Gash.

(a) RESIDENCE NO. 2808 Walbrook Ave St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | white | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Effie Gash

6 DATE OF BIRTH (month, day, and year) May 17, 1853

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 73 | 8 | 14 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lithographer

(b) General nature of industry, business, or establishment in which employed (or employer) Peters 163

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Md.

PARENTS

10 NAME OF FATHER August Gash

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Germany

12 MAIDEN NAME OF MOTHER Zukauskas

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Indiana

14 Informant Mrs. Effie Gash

(Address) 2808 Walbrook Ave

15 Date Feb. 2, 1927 C. HARRISON JONES, M. D.

Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 31, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ____ yrs. ____ mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. C. Hemmeter M. D.

(Coroner)

Feb. 2, 1927 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. Date of Burial Feb. 3 1927

20 UNDERTAKER Wm Cook ADDRESS 502 E North Ave.

OF DEATH in plain terms, describing the cause to the disease causing death, or in violent deaths the manner and means of injury. State whether accident, suicide or homicide. This information is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18610

E 18610

## CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Howard A. Kelly Hospital ST., ..... WARD)

2-FULL NAME Mrs. Marg. L. Edwards.

(a) RESIDENCE NO. 118 - 14th St., S.E. ST., ..... WARD Washington, D.C.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 4 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — Mr. Wm. A. Edwards.

6 DATE OF BIRTH (month, day, and year) July 11/1874

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs or ..... min. |
|---|---|---|---|---|
| | 52 | 6 | 28 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) Hornell
(State or country) N.W. York

PARENTS

10 NAME OF FATHER Joseph Mounce

11 BIRTHPLACE OF FATHER (city or town) Devonshire
(State or country) England

12 MAIDEN NAME OF MOTHER Jane Plain

13 BIRTHPLACE OF MOTHER (city or town) York
(State or country) England

14 Informant Miss Marion L. Edwards
(Address) 118 14th St N.E. Washington D.C.

15 Filed 2 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 2 1927

17 I HEREBY CERTIFY, That I attended deceased from March 17, 1922, to Feb. 2, 1927, that I last saw her alive on Feb. 2, 1927, and that death occurred, on the date stated above, at 3 30 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of cervix (Squamous cell)

(duration) 7 yrs. mos ds.

CONTRIBUTORY (Secondary) none —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Washington D.C.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Biopsy

(Signed) Robert E. Fridell, M. D.

, 19 (Address) 1418 Eutaw Place, City

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D.C. — DATE OF BURIAL Feby 2 1927

20 UNDERTAKER Chas. G. Black — ADDRESS 742 W. Northam

TION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 18611 HEALTH DEPARTMENT—CITY OF BALTIMORE 44 E 18611

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 914 West Baltimore St., 18-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leah Mittman

(a) RESIDENCE NO. 914 West Baltimore St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. 7 mos. ds. How long in U. S., if of foreign birth? 27 yrs. 7 mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | white | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Herman Mittman

6 DATE OF BIRTH (month, day, and year) unknown

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 52 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Antonia

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Antonia

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant L. Mittman (Address) 914 W. Baltimore St

15 FILED B-3 1927 19 C. HARRY JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/3/27 19

17 I HEREBY CERTIFY, That I attended deceased from January 24, 1927, to February 2, 1927,

that I last saw her alive on February 2, 1927

and that death occurred, on the date stated above, at 12:30 m

The CAUSE OF DEATH* was as follows:

Cancer of the Stomach

Cancer of the Liver

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Myocardosis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? X Ward (Kelly's Service)

(Signed) X. A. M. A. Mayer, M. D.

2/3, 1927 (Address) 2438 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Cemetery

DATE OF BURIAL 2/3 1927

20 UNDERTAKER Jack Lewis 1439 E Eager St

ADDRESS

Cor.—12-9-25—A Co.—200 Bks.

E 18612

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

9-46 90 E 18612

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 723 E. 22nd St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Hartman

(a) RESIDENCE NO. 723 E. 22nd St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | Widower |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Hartman

6 DATE OF BIRTH (month, day, and year) Dec 16/1879

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 47 | 1 | 15 16 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Highways & Sewerage Dept.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balto. City, Md.

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Charles Hartman

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Steinberg

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs Alice F. Hartman

(Address) 723 E. 22nd St

15 Filed ..... 19..... [illegible] Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 1, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocarditis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. McPaul, M. D.

(Coroner)

2/2/27 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Date of Burial Feb-3. 1927

20 UNDERTAKER Rida Wiedefeld ADDRESS 9 W Fremont Ave

FEB 3 1927 C. HARRIS [illegible] M. D.

For certificate, see reverse side of this certificate. OF DEATH is printed very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129

E 18613
1-PLACE OF DEATH

E 18613
REGISTERED NO.

City of BALTIMORE: (No. 1145 May St., 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E Sowers

(a) RESIDENCE NO. 1145 May St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: C

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

3a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ernest Sowers

6 DATE OF BIRTH (month, day, and year): Nov 11 1879

7 AGE: Years 47 | Months N[2] | Days 20 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town): St Mary's County Md

(State or country)

PARENTS

10 NAME OF FATHER: Albert Watling

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Monroe

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md

14 Informant: Josephine Jones

(Address): 1145 N May St

Filed ..... 19 ..... C. HARTZELL JR. Registrar

FEB - 3 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 31 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 20, 1927, to Jan 31, 1927, that I last saw h[er] alive on Jan 31, 1927, and that death occurred, on the date stated above, at 12.45 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 5 mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) yrs. 5 mos. ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

20 (Signed) Geo. Gillespie, M. D.

Jan 27 1927 (Address) 5 E Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery Date of Burial 2/2/27

UNDERTAKER: Wm. P. G. Ent ADDRESS 17 Litchfield

OF DEATH in part (1), (2), and (3) are very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 18614
1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

3-4

REGISTERED NO. E 18614

City of BALTIMORE: (No. Johns Hopkins Hospital St. 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lucielle Hayes

(a) RESIDENCE NO. 219 S. Bethel St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | col | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) 1893

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 34 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Va

PARENTS

10 NAME OF FATHER Preston Blake

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Nellie Brown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Nellie Hayes

(Address) 1007 Lombard St

15 Filed 19 C. Hall Jones M. D. Registrar

FEB - 3 1927

By K.K.

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 1/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Hall, M. D.
(Coroner)

2/2/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL asbury cemetery Date of Burial Feb 4 1927

20 UNDERTAKER E. Edward Bryan ADDRESS 1691 orleans st

OF DEATH in plain terms, stating very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18615

## CERTIFICATE OF DEATH.

90

E 18615

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 411 N Popplelon St., 18-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Georgiana Roff

(a) RESIDENCE NO. 411 N Popplelon St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Wid

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1864

7 AGE: Years 63 | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant: Norman J. Roff

(Address) 908 Penna Ave

Filed FEB - 3 1927 C. HARTON JONES, M. D. Registrar

Per RR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 1 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan 15, 1927, to Feb 1, 1927, that I last saw h..... alive on Jan 31, 1927, and that death occurred, on the date stated above, at 12 45 P.M.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W J Norman M. D.

Feb 1, 1927 (Address) 937 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem Date of Burial: Feb 4 1927

20 UNDERTAKER: David Easton ADDRESS 916 Gay

Instructions: Use typewriter or pen and ink. Write plainly. Do not use pencil. Be sure to fill all items. If unknown, say so. Do not leave blanks. Use figures for dates. Sign certificate. Report to Registrar of district in which death occurred. Burial permit will be issued by Registrar upon presentation of this certificate properly filled out. See instructions on back of certificate. Very important.

Spec.—12-9-25—A Co.—200 Bks.

19773

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90

E 18616

1-PLACE OF DEATH

REGISTERED NO. E 18616

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (Ward) Johns Hopkins Hospital St., 15-21 Ward)

2-FULL NAME Florence Fisher

(a) RESIDENCE NO. 1422 N. Gilmor St. City Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | Colored | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Fisher

6 DATE OF BIRTH (month, day, and year) 1878

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 49 yrs. | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER Wesley Clautz

11 BIRTHPLACE OF FATHER (city or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Margaret Squires

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Texas

(Address) Johns Hopkins Hospital

15 Filed FEB - 3 1927 C. HERBERT JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 2 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 31, 1927, to Feb. 2, 1927, that I last saw her alive on Feb. 2, 1927, and that death occurred, on the date stated above, at 5-20 p. m.

The CAUSE OF DEATH* was as follows: Arteriorderosis Hypertension Cardiac hypertrophy Myocardial insufficiency

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Milton Sherry, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem Date of Burial Feb 3 1927

20 UNDERTAKER Samuel Eaton ADDRESS 916 Eutaw

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18617

## CERTIFICATE OF DEATH.

8-17 170

E 18617

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joesph's Hospital St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John McCullough

(a) RESIDENCE NO. 1534 N. Bond St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth S. McCullough

6 DATE OF BIRTH (month, day, and year) July 19th. 1858

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 68 | 6 | 12 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) (Retired)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John McCullough

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Gourley

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Elizabeth S, McCullough

(Address) 1534 N. Bond St.

15 Filed C. HARRISON JONES, M. D. Registrar

EB - 3 1927

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 1st. 1927 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) Inquiry had that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Pistol Shot in rt mastoid region.

Suicide

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) H. H. Eaton M. D.

(Coroner)

2/2/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs., .....mos., .....ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. Date of Burial Feb 4th 1927

20 UNDERTAKER Philip Stenig ADDRESS 2016 Arlington Ave.

Cut on dotted line and deliver certificate. See instructions on back of certificate. Certificate of Death is void unless very important.

18618

[illegible]-11-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18618

## CERTIFICATE OF DEATH

1-PLACE OF DEATH — REGISTERED NO. 45-21

City of BALTIMORE: (No. Providence Hospital St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Washington

(a) RESIDENCE NO. 1732 Prestman St. Ward 5

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 5 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| M. | C | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Washington

6 DATE OF BIRTH (month, day, and year) Mch 14-1893

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 33 | 10 | 18 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laboer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Wilmington N. C.

(State or country)

PARENTS

10 NAME OF FATHER George Washington

11 BIRTHPLACE OF FATHER (City or town) N. C.

(State or country)

12 MAIDEN NAME OF MOTHER Julia Brown

13 BIRTHPLACE OF MOTHER (city or town) N. C.

(State or country)

14 Informant Annie Washington

(Address) 1732 Prestman

Filed FEB - 3 1927 H. [illegible] JAMES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 1 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 21, 1927, to Feb. 1, 1927.

that I last saw h[illegible] alive on Feb. 1, 1927.

and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH was as follows:

Lobar Pneumonia

(Unresolved)

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. ? mos. ds.

18 Where was disease contracted

If not at place of death? 1732 Prestman St.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings.

(Signed) John W. Gaines M. D.

2-1-1927 (Address) Providence Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Cem. — Date of Burial Feb 3 1927

20 UNDERTAKER Sam'l N. Chase & Son — ADDRESS 1400 N. Gaker

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18619

## CERTIFICATE OF DEATH

38

E 18619

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1306 W. Lexington St., 14-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Zecia Kuhn

(a) RESIDENCE NO. 1306 W. Lexington St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 15, 1879

7 AGE: Years 47 Months 4 Days 17 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Hagerstown Md

PARENTS

10 NAME OF FATHER James Kuhn

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Md.

12 MAIDEN NAME OF MOTHER Mary Boyd

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md.

14 Informant: Jesse Slaughuff

(Address): Md Tubes Bldg

15 Filed ... 19 ... C. H. ... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 2 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 25, 1927, to Feb 2, 1927, that I last saw h[illegible] alive on Jan 29, 1927, and that death occurred, on the date stated above, at 11:15 a.m.

The CAUSE OF DEATH* was as follows:

Cardio-Spinal Syphilis

(duration) 7 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Paralysis of Lower Extremities (duration) 4 yrs. — mos. — ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Lab. Tests

(Signed) Dr Chas E. Corbett, M. D.

19 (Address) Latrobe Apts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park. Date of Burial 2/4 19 27

20 UNDERTAKER George J Smith ADDRESS 1532 Hollins

FEB 3 1927

OF DEATH in plain terms, and underline the words very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 18620

57

E 18620

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospital St., 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edith Cooksey

(a) RESIDENCE NO. 1631 Division St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | Col | Married. |

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) December

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 61 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Canada

(State or country)

PARENTS

10 NAME OF FATHER William Brown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Hospt Records

(Address)

FEB 3 1927

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30, 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec. 11, 1927, to Jan. 30, 1927, that I last saw h... alive on Jan. 30, 1927 and that death occurred, on the date stated above, at 8 30 m.

The CAUSE OF DEATH* was as follows:

Generalized Arteriosclerosis

Diabetes Gangrene of Both feet.

duration ... mos. ... ds.

CONTRIBUTORY (Secondary) Terminal Bronchopneumonia

duration ... yrs. ... mos. 2 ds.

18 Where was disease contracted Home

If not at place of death!

Did an operation precede death? No Date of Jan. 10, 1927

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Signs & Laboratory

(Signed) ... M. D.

, 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart — Date of Burial 2/3 1927

20 UNDERTAKER J J Fahey Sons — ADDRESS 1818 S. Light St

Of importance to the State and very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18621

## CERTIFICATE OF DEATH.

31 ✓ E 18621

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. T B 216-37 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Vargos

(a) RESIDENCE NO. None St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1882

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 45 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town)

(State or country) Mexico

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Mexico

14 Informant Hospital records

(Address)

15 Filed FEB 3 1927 19 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 January 30, 1927

17

I HEREBY CERTIFY, That I attended deceased from January 29, 1927, to January 30, 1927,

that I last saw him alive on January 30, 1927,

and that death occurred, on the date stated above, at 6.30 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) M. D.

1-31-27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Date of Burial 2/2 1927

20 UNDERTAKER J J Fahey Sons ADDRESS 1318 Light St

Of DEATH please print plainly. very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18622

E 18622

## CERTIFICATE OF DEATH.

182

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 700 E. Bond. ST., 2-4 WARD)

2-FULL NAME John, Tolin (Tolin)

(a) RESIDENCE NO. 62 ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| M. | White | Not Known |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Not Known

6 DATE OF BIRTH (month, day, and year) 1852

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs. or ....min. |
|---|---|---|---|---|
| about 45 | | | | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Oiler
(b) General nature of industry, business, or establishment in which employed (or employer) do
(c) Name of employer

9 BIRTHPLACE (city or town) Unknown
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14
Informant .....
(Address) .....

15 Filed FEB - 3 1924 C. HARRISON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jan 25/24 J. C. Blades, M. D.
(Coroner)

(Address) 1437 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ..... mos., ..... ds. In the State ..... yrs., ..... mos., ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 192

20 UNDERTAKER — ADDRESS

PUBLIC CEMETERY
Commissioner Health
FEB 3 1924

Cor.—12-9-25—A Co.—200 Bks.

E 18623

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1930

E 18623

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1118 E Fayette St., 5-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Pete Williams

(a) RESIDENCE NO. 11 St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Col. | Widower |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1862

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 65 | | | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Odd
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

15 Filed 19

Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Found dead Jan 3 - 29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Exposure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Found dead Jan 3 - probably lying dead 3 days

(Duration) yrs. mos. ds.

(Signed) W. T. Kelly M. D.

(Coroner)

Jan 29 1929 (Address) 16 E Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 19

PUBLIC CEMETERY

20 UNDERTAKER ADDRESS

C. HARRISON JONES, M. D.

FEB - 3 1929 HOMEPATH

Commissioner Health.

FEB 5 1929

Per Wm. S. Wortman

very important. See instructions on back of certificate.

Spies

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 18624

# CERTIFICATE OF DEATH

E 18624

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 654 Pitcher St. St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Spies

(a) RESIDENCE NO. 654 Pitcher St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew J. Spies

6 DATE OF BIRTH (month, day, and year) Feb. 2 1859

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|---|
| | 67 | 11 | 29 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Wenzel Marshall

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Anna

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany.

14 Informant Andrew J. Spies

(Address) 654 Pitcher St.

15 Filed FEB - 3 1927 C. H. [illegible] Registrar.

Per K.K.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/1 19 27

17 I HEREBY CERTIFY, That I attended deceased from 10/7, 19 26, to 2-1, 19 27, that I last saw h[illegible] alive on 2-1, 19 27, and that death occurred, on the date stated above, at 9.30 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Cardiac decompensation

Lobar Pneumonia

(duration) not stated ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Typical Sign

(Signed) Samuel [illegible] M. D.

. 19 27 (Address) 3325 Reisterstown

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| New Cathedral Cem. | Feb. 4th 1927 |
| 20 UNDERTAKER Lilly & Zeiler | ADDRESS 403 S. Wolfe St. |

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 18625

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18625

## CERTIFICATE OF DEATH.

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 118 N Beverly St. 23-31 Ward)

2-FULL NAME John Herrmann.

(a) RESIDENCE NO. 118 N Beverly St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Herrmann

6 DATE OF BIRTH (month, day, and year) Not Known

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 70 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Sailor

(b) General nature of industry, business, or establishment in which employed (or employer) 080

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Germany.

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Germany.

14 Informant Mrs. Frank Herrmann

(Address) 118 N Beverly St

3 1927 C. HAMPSON JONES, M. D. Registrar

By RRH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-1st 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 22 1927, to 2-1 1927

that I last saw h..... alive on _____, 19.....,

and that death occurred, on the date stated above, at 5.15 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

Direct Known (duration) yrs. mos. ds.

CONTRIBUTORY _____

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? _____

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Edward Norris, M. D.

2-2, 1927 (Address) 107 Ewell

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem. Date of Burial 2-5 1927

20 UNDERTAKER Earl B Hale ADDRESS 115 E West St

- very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18626

## CERTIFICATE OF DEATH.

1926-17

REGISTERED NO. E 18626

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Maryland General (St.) (Hospital) (Ward)

2-FULL NAME Mrs. J. Frederick Loenig

(a) RESIDENCE NO. 1120 8th Street (St.) Morell Park (Ward)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Mary Loenig

6 DATE OF BIRTH (month, day, and year) Feb 2, 1865

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 62 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor 080

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Frederick Loenig

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Charles Loenig (Address)

15 Filed FEB 3 1927 C. HAMPSON JONES, M. D. Registrar Per A.K.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 1 1927

17 I HEREBY CERTIFY, That I attended deceased from 1-31- , 1927 , to 2-1 , 1927 .

that I last saw him alive on 2-1-27 , 19 ,

and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Strepto coccus Peritonitis

(duration) yrs. mos 3 (3) ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. 3 (3) ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 1-31-27

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) C. C. Zimmermann, M. D.

, 19 (Address) Bd. Gen'l Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 2-4 1927

20 UNDERTAKER Wm. Charles & J. Rohde

ADDRESS 600 N. Arlington Ave

TION is very important. See instructions on back of Certificate

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 18627

E 18627

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Cherry Hill St. 25-32 Ward)

2-FULL NAME Genevr E Hartman

(a) RESIDENCE NO. Cherry Hill St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 7 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 19 1925

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 1 | 2 | 14 15 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Casper Hartman

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country) Md.

12 MAIDEN NAME OF MOTHER Etta R Goodrich

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md.

14 Informant Casper Hartman.

(Address) Cherry Hille

15 Filed ..... 19 ..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-3-1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1927 to Jan 3, 1927.

that I last saw alive on Jan 3, 1927.

and that death occurred, on the date stated above, at 3 9 m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar pneumonia.

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jos A Scherer, M. D.

19 (Address) 1537 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cem Date of Burial 2-5 1927

20 UNDERTAKER: E & F B Harle ADDRESS 1156 E Fayette St

Of Births and Deaths. very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

E 18628

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E-18628

## CERTIFICATE OF DEATH

X 124

1-PLACE OF DEATH University Hospital — REGISTERED NO. 4-30

City of BALTIMORE: (No. ____ St. ____ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry R Lowman

(a) RESIDENCE NO. 15 Brewer Ave - St. Annapolis Md Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S. if of foreign birth? yrs. mos ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Lowman

6 DATE OF BIRTH (month, day, and year) ? 1893

| 7 AGE | Years | Months | Days | IF LESS than 1 day ____ hrs. or ____ min.. |
|---|---|---|---|---|
| | 34 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Printer 063

(b) General nature of indostry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland.

(State or country)

PARENTS

10 NAME OF FATHER Rason Lowman

11 BIRTHPLACE OF FATHER (City or town) ____

(State or country) md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ____

(State or country) md

14 Informant Hospital Record.

(Address)

15 Filed 3 1927 C. HAMPSON JONES, M. D. Registrar

Per ____

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 2 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1927 to Feb 2 1927

that I last saw h[illegible] alive on Feb 2 1927

and that death occurred, on the date stated above, at 3:20 P.M.

The CAUSE OF DEATH* was as follows: Hemolytic Jaundice

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Pernicious

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? Yes Date of Jan 27 Removal of Spleen

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) J. M. Hundley M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Annapolis Md | Feb 6 1927 |
| **20 UNDERTAKER** | **ADDRESS** |
| Taylor & Sons. | Annapolis Md |

IMPORTANT—Fill in plainly, and be sure to answer every question. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18629

## CERTIFICATE OF DEATH

100-001 E 18629

REGISTERED NO. _____

1-PLACE OF DEATH

City of BALTIMORE: (No. 2518 Hudson St. 1-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Rostkowski

(a) RESIDENCE NO. 2518 Hudson St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| M | W | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 18 1926

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|---|
| | | 1 | 14 15 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER Peter Rostkowski

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Katherine Sierak

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md

(State or country)

14 Informant Mrs Katherine Rostkowski

(Address) 2518 Hudson St

15 Filed 2-3-1927 I. C. HAMPSON JONES M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2 - 2 - 1927

17 I HEREBY CERTIFY, That I attended deceased from 2 - 1 - 1927 to 2 - 2 - 1927

that I last saw him alive on 2 - 2 - 1927

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 1/24

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical signs

(Signed) J. J. Mahoney M. D.

19 (Address) 3037 Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

St Stanislaus Cem Feb 4 1927

20 UNDERTAKER — ADDRESS

John A Weber 1803 Bank St

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18630

E 18630

## CERTIFICATE OF DEATH.

99-00

15-21

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1823 N. MONROE ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME HENRIETTA W. HILGARTNER

(a) RESIDENCE NO. LONG GREEN MD ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? 76 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| FEMALE | WHITE | WIDOW |

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of LATE HENRY HILGARTNER

6 DATE OF BIRTH (month, day, and year) DEC-5-1846

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs or ... min. |
|---|---|---|---|---|
| | 81 | 1 | 28 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work HOUSEWIFE

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) GERMANY

PARENTS

10 NAME OF FATHER CONRAD BACHMAN

11 BIRTHPLACE OF FATHER (city or town) GERMANY (State or country)

12 MAIDEN NAME OF MOTHER ELIZABETH MOST

13 BIRTHPLACE OF MOTHER (city or town) GERMANY (State or country)

14 Informant N. S. Schmidt

(Address) Long Green Md

15 Filed FEB 3 1927 19... C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 3 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 25th, 1927, to Feb 2, 1927, that I last saw her alive on Feb 2nd, 1927, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilitation

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Bronchitis + Cystitis

(duration) ... yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) William J Hessick M. D.

, 1927 (Address) 1700 Lindenwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ST. JOHN'S LUTHERAN CEMETERY BLENHEIM MD

DATE OF BURIAL FEB 6 1927

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor)

ADDRESS 108 W. NORTH AVE.

ITION IS VERY IMPORTANT

Spec.–7-17-26—A Co.—200 Bks.

E 18631

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18631

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Provident Hospital St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Rogers

(a) RESIDENCE NO. Juniors Ky St. Ward Juniors Ky.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Col | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline Rogers

6 DATE OF BIRTH (month, day, and year) 1892

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min.. |
|---|---|---|---|---|
| | 35 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Juniors Ky

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Hospital records

(Address) 430 Biddle

15 Filed 3 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-31-1927

17 I HEREBY CERTIFY, That I attended deceased from 1-21-, 1927, to 1-31, 1927, that I last saw h.. alive on 1-31, 1927, and that death occurred, on the date stated above, at 1 0a m.

The CAUSE OF DEATH* was as follows:

Hypostatic pneumonia

Epithelioma Penis

Coronary Occlusion & heart failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of 1/31/27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. Jackson, M. D.

2/3, 1927 (Address) 50 S Wolfe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Juniors Ky. Date of Burial 2/3 1927

20 UNDERTAKER Samuel H. Kinsley ADDRESS 500 Biddle

OF DEATH is plain letters, as ... very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18632

CERTIFICATE OF DEATH.

49 E 18632

1-PLACE OF DEATH Mercy Hospital

City of BALTIMORE: (No. ) 18-26 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gerard Heckert -

(a) RESIDENCE NO. 538 N. Carrollton Av - St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year) Oct 30 1850

7 AGE: Years 76 | Months 3 | Days 2 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar Maker

(b) General nature of industry, business, or establishment in which employed (or employer) 017

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland

(State or country)

PARENTS

10 NAME OF FATHER John Heckert

11 BIRTHPLACE OF FATHER (city or town) Bavaria

(State or country)

12 MAIDEN NAME OF MOTHER Catharine Sund

13 BIRTHPLACE OF MOTHER (city or town) Bavaria

(State or country)

14 Informant Hospital Record

(Address) C. HAMPSON JONES, M. D.

15 Filed 3 1927 19 Per Rich Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 2 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 12 8 1926, to Feb. 2, 1927, that I last saw him alive on Feb 2, 1927, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of 1/12/27

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. Motta, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem Date of Burial 2/5 1927

20 UNDERTAKER Wyse & Farley ADDRESS Sutton & Fayette

Instructions. See instructions on back of certificates. very important.

Spec.—1-12-23—M&T—500 Bks.

E 18633 HEALTH DEPARTMENT—CITY OF BALTIMORE E 18633

CERTIFICATE OF DEATH.

1-PLACE OF DEATH West Baltimore General Hospital

CITY OF BALTIMORE: (NO. Raynor and Dukeland St. WARD) 17-50 101

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Iwalt Kemp

(a) RESIDENCE NO. 322 Wyman Ave. ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Female | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Kemp

6 DATE OF BIRTH (month, day, and year) Aug. 22, 1875

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 51 | 5 | 12 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Saleslady

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Stewart & Company

9 BIRTHPLACE (city or town) (State or country) Anne Arundel Co., Md.

PARENTS

10 NAME OF FATHER Thomas E. Arnold

11 BIRTHPLACE OF FATHER (city or town) (State or country) Anne Arundel Co., Md.

12 MAIDEN NAME OF MOTHER Eugenia Mewburn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Anne Arundel Co., Md.

14 Informant Frank A. Kemp
(Address) 322 Wyman Avenue

15 Filed FEB 3 1927, 19 C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/3 1927

17 I HEREBY CERTIFY, That I attended deceased from 1/30, 1927, to 2/3, 1927, that I last saw h[illegible] alive on 2/3, 1927 and that death occurred, on the date stated above, at 9:45 A. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos 1 0 ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Benjamin Miller M. D.

Feb 3. 1927 (Address) W. B. G. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Hough Chapel, Benton, Md. | Feb. 4, 1927 |

20 UNDERTAKER Joseph B Cook ADDRESS 1003 W Balto St

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18634

## CERTIFICATE OF DEATH

E 18634

REGISTERED NO. 24081

1-PLACE OF DEATH

City of BALTIMORE: (No. 1327 Sargent St. 21-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Watts

(a) RESIDENCE NO. 1327 Sargent St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 30 1849

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 67 | 8 | 2 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER William H Watts

11 BIRTHPLACE OF FATHER (City or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Eliza Watts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant John X Watts (Address) 3 West Fayette

15 Filed JAN 3 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 2 1927

17 I HEREBY CERTIFY, That I attended deceased from 2-1-, 1927, to 2-2-, 1927 that I last saw him alive on 2-2-, 1927 and that death occurred, on the date stated above, at 11 00 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 7 mos ds.

13 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Helen Dunn, M. D.

, 19 (Address) 1327 Sargent St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Glenwood Md. Fst.

Date of Burial 2 1927

ADDRESS

20 UNDERTAKER Wm Cook 330 E Balto

OF DEATH in plain English. See instructions on back of certificates. very important.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18635

## CERTIFICATE OF DEATH

100-281 E 18635

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No.) St Agnes Hosp. (St.) 16-68 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bab Simms (Walter A Simms)

(a) RESIDENCE NO. ~~St Agnes Hosp~~ 8021 Cuba and St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX ~~Female~~ Male.

4 Color or Race White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 1, 1927

7 AGE Years 0 Months 1 Days 1 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind af work Baby

(b) General nature af industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md.

PARENTS

10 NAME OF FATHER Frederick Simms

11 BIRTHPLACE OF FATHER (City or town) Balto

(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Jacobs

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md

14 Informant Mary Simms

(Address) 8021 Cuba and St.

15 3 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 2 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1927, to Feb 2, 1927,

that I last saw h[illegible] alive on Feb 2, 1927,

and that death occurred, on the data stated above, at 8 30 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 4 da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation preeede death? No Data of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W P McBride, M. D.

, 19 (Address) Wayne Harlem

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Aecidental, Suieidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters Cemetery

Date of Burial 2/4 1927

20 UNDERTAKER Wm Cook

ADDRESS 502 E North

Certificates.

very important. See instructions on back of certificate

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

18636

E 18636

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Maryland Gen Hosp 27-42 117 REGISTERED NO.

CITY OF BALTIMORE: (No. ... St. ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John F Hoover

(a) RESIDENCE NO. Summerfield Ave ST., Baltimore

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Estelle Hoover

6 DATE OF BIRTH (month, day, and year) Feb 20, 1882

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 44 | 11 | 8 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Moulder. 047

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Illinois

PARENTS

10 NAME OF FATHER Michael Hoover.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn.

12 MAIDEN NAME OF MOTHER Harriet Bigham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Illinois

14 Informant John F Hoover.

(Address) Summerfield Ave

15 Filed 3 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 2 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 31, 1927, to Feb 2, 1927, that I last saw him alive on Feb. 2, 1927, and that death occurred, on the date stated above, at 4.10 a.m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

Paralytic Ileus, due to

(duration) yrs. 2 mos 9 ds.

CONTRIBUTORY (Secondary) Pneumonia, lobular

(duration) yrs. ... mos. 7 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes Date of Feb. 1, 1927.

Was there an autopsy? not.

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Forkland — DATE OF BURIAL Feb 5 1927

20 UNDERTAKER Wallace Cook — ADDRESS 502 E North Ave

TION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18637

## CERTIFICATE OF DEATH.

90 E 18637

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 1334 N. Fremont St. 15-70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Katherine Knapp.

(a) RESIDENCE NO. 1334 N. Fremont St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| F. | Wh | Widow |

5a If married, widowed, or divorced (or) ~~WIFE~~ of Late John Knapp.

6 DATE OF BIRTH (month, day, and year) Not known Jan 1853

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 74 | 1 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Germany

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Ger.

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Ger.

14 Informant Mrs. Williams Dau

(Address) 1334 N Fremont Av

15 Filed July 5 1927 J. C. HARRISON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2nd 1927 19

17 I HEREBY CERTIFY, That I attended deceased from June 30, 1927, to July 2nd, 1927, that I last saw h__ alive on July 2nd, 1927, and that death occurred, on the date stated above, at 9:30 a. m.

The CAUSE OF DEATH* was as follows:

Lobular Pneumonia

(duration) ____ yrs. ____ mos. 6 ds.

CONTRIBUTORY (Secondary) Fell in floor and could not make family hear during cold and cloth

(duration) ____ yrs. ____ mos. 5 Days

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? _____

(Signed) Endorsed, M. D.

7/2, 1927 (Address) 1606 N Monroe St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Mt Olivet Cemetery | 7/5 1927 |
| 20 UNDERTAKER Wm Cook | ADDRESS 502 E North Ave |

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18638

E 18638

## CERTIFICATE OF DEATH.

27-44 90

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 14 Willax Avenue Raspeburg ST., 26 WARD)

2-FULL NAME Rocco Garzilli

(a) RESIDENCE No. 14 Willax Avenue Raspeburg ST., 26 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? 29 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Garzilli (nee Moncrasse)

6 DATE OF BIRTH (month, day, and year) March 12, 1859

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or ..... min. |
|---|---|---|---|---|
| | 67 | 10 | 21 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Groceryman, retired

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) ..... Italy
(State or country)

PARENTS

10 NAME OF FATHER Gaetano Garzilli

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Rubina Romeno

13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

14 Informant Victor Damantasio
(Address) 14 Willax Ave.

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 2, 1927

17 I HEREBY CERTIFY, That I attended deceased from January 31, 1927 to February 1, 1927, that I last saw him alive on February 1, 1927, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

6 Hrs.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis

(duration) yrs. ? mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No .....

What test confirmed diagnosis? .....

(Signed) A. L. Wilkinson, M. D.
A. L. Wilkinson

2/2. 1927 (Address) 13 E. Belair Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Feb 4 1927

20 UNDERTAKER Wm Cook

ADDRESS 502 E North Ave

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 18639

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18639

## CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fred. Dittmar

(a) RESIDENCE NO. 1834 Pennsylvania Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Dittmar

6 DATE OF BIRTH (month, day, and year) Sept 4-1866

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 60 | 4 | 28 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker

(b) General nature of industry, business, or establishment in which employed (or employer) Bkr

(c) Name of employer

9 BIRTHPLACE (city or town) Germany (State or country)

PARENTS

10 NAME OF FATHER Charles Dittmar

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER L. Leimbach

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Otto Dittmar (Address) 1834 Pennsylvania Ave

15 Filed 2/7 19 27 HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/2 1927

17 I HEREBY CERTIFY, That I attended deceased from 1/23, 1927, to 2/2, 1927, that I last saw him alive on 2/2, 1927, and that death occurred, on the date stated above, at 8 45 Pm.

The CAUSE OF DEATH* was as follows:

Benign Prostatic Hypertrophy with urinary retention and uremia -

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis, Cardiac dilatation (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical. Lab.

(Signed) John A. Sperry M. D.

, 19 (Address) Med. Journal Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL 2/5/27

20 UNDERTAKER Geo Leimbach & Son — ADDRESS Caton Pratt

TION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 18640

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-06

E 18640

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1524 Holbrook St. 9-18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph C Fenster

(a) RESIDENCE NO. 1524 Holbrook St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. da. How long in U. S. if of foreign birth? yrs. mos. da.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec 30, 1877

7 AGE — Years: 49 Months: 1 Days: 1 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cigar Cutter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Self

9 BIRTHPLACE (city or town): Balto.

(State or country): Md.

PARENTS

10 NAME OF FATHER: Richard Fenster

11 BIRTHPLACE OF FATHER (City or town): Balto

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Mary O'Donnell

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Ca

14 Informant: Mrs Marie Raysinger

(Address): 502 E Randall St

15 Filed ..... By ..... Registrar

B - 3 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 1 1927

17 I HEREBY CERTIFY, That I attended deceased from January 26 1927 to Feb 1 1927 that I last saw h[illegible] alive on Feb 1 1927 and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) ..... yrs. mos. 3 da.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

Jan 27 1927 (Address) 1206 Presbrey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross (Cath)

Date of Burial: Feb 1 1927

20 UNDERTAKER: [illegible] Cook

ADDRESS: 502 E Randall

Be sure that your answers are very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18641

# CERTIFICATE OF DEATH.

101-09

E 18641

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1620 Ellamont St., 16-67 Ward)

2-FULL NAME Mary A. Falkenstein.

(a) RESIDENCE NO. 1620 Ellamont St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. 25 How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female,

4 Color or Race: White,

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan, 11, 1847.

7 AGE — Years: 80, Months: — Days: 23. IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland.

PARENTS

10 NAME OF FATHER Henry Falkenstein.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Catherine Kaiser.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany.

14 Informant Louis R. Falkenstein.

(Address) 1620 Ellamont Ave.

3-1927 C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 13

Feb. 3 - 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan 8th, 1927, to Feb. 2nd, 1927, that I last saw her alive on Feb. 2nd, 1927, and that death occurred, on the date stated above, at 8. a. m.

The CAUSE OF DEATH* was as follows:

Senile Lobar Pneumonia

(duration) ..... yrs. 1 mos. 20 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Isaac C Dickson, M. D.

, 19 (Address) 3055 N. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF REMOVAL, CREMATION OR BURIAL: Louden Pk Cem Fel 4 1927 Date of Burial

20 UNDERTAKER: C. L. and Evans ADDRESS: 38 E Fort ave.

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18642

## CERTIFICATE OF DEATH.

181-001

E 18642

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1610 E Bank St., 3-4 (Ward)

2-FULL NAME Mary Porcella

(a) RESIDENCE NO. 1610 E Bank St. Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? 42 yrs. 7 mo. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| F | W | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Angelo Porcella

6 DATE OF BIRTH (month, day, and year) June 9 1876

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 50 | 7 | 23 | |
| | 51 years 8 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Keeping

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Italy

PARENTS

10 NAME OF FATHER Italy

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Antony Solari

12 MAIDEN NAME OF MOTHER Catherine Mare

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Italy

14 Informant _____

(Address) 1610 Bank St

Feb 3 1927 C. HAMPSON JONES, M. D.

By _____ Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 2 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH was as follows:*

Acc. Gas Poisoning

Duration ..... yrs. ..... mos. 5 hrs.

CONTRIBUTORY (Secondary) _____

Duration ..... yrs. ..... mos. ..... ds.

Feb 3 1927 Signed) Jos. Collins Spade (CORONER) M. D.

(Address) 143 E 19 Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mo. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Date of Burial Feb 5 1927

20 UNDERTAKER Wendell Dyffel & Son ADDRESS 318 N

very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18643

## CERTIFICATE OF DEATH.

90 E 18643

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 814 N. Monford Ave. WARD) 7-12

2-FULL NAME Albert Duban.

(a) RESIDENCE NO. 814 N. Montford Ave. STR. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male. | White | Married. |

5a If married, widowed, or divorced HUSBAND of ~~(or) Wife of~~ Caroline Duban.

6 DATE OF BIRTH (month, day, and year) April 1861

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 65 | 10 | 11 | |

8 OCCUPATION OF DECEASED. Day Laborer

(a) Trade, profession or particular kind of work City Department.

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia.

PARENTS

10 NAME OF FATHER Frank Duban.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia.

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia.

14 Informant Caroline Duban.

(Address) 814 N. Monford Ave.

15 Filed B - 4 1927 19 C. HAMPTON JONES, Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 3, 1927.

17 I HEREBY CERTIFY, That I attended deceased from 1-30 27, to 2-3, 1927.

that I last saw h alive on 2-3, 1927

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Acute Cystitis, Hypostatic Pneumonia, Mitral Regurgitation (Acute)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Fred Singer, M. D.

(Address) 1000 Hull St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cap Hill Cem.

DATE OF BURIAL Feb. 6 1927

20 UNDERTAKER August Sasse

ADDRESS 2406 Ashland Ave.

Spec.—I-10-21—M&T—1500 Bks.

E 18644

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 18644

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1009 W. Lafayette Ave (WARD) 16-2390 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christiana Young

(a) RESIDENCE NO. 1009 W. Lafayette Ave, WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Dennis Young.

6 DATE OF BIRTH (month, day, and year): Unknown 1861

7 AGE: Years 65 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Elizy Griggs

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Dennis Young (Address) 1009 W. Lafayette ave

FEB - 4 1927 C. HARTLEY JONES, M. D. Registrar

By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 2 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 25, 1927, to Feb 2, 1927, that I last saw h[illegible] alive on Feb 1, 1927, and that death occurred, on the date stated above, at 1.30 a m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. B. Laird, M. D.

2/3, 1927 (Address) 2005 Hillsdale Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Auburn Cem.

DATE OF BURIAL: 2/4 1927

20 UNDERTAKER: John H. Toadvine

ADDRESS: 902 Druid Hill Ave.

ATTENTION is very important. See instructions on back

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 18645 — REGISTERED NO.

E 18645 — 1-PLACE OF DEATH

City of BALTIMORE: (No. 410 W Hamburg St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hattie Hester

(a) RESIDENCE NO. 1072 W Fairmount Ave St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: Colored

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John H Ester

6 DATE OF BIRTH (month, day, and year): Unknown 1880

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 47 | 6 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Va

(State or country)

PARENTS

10 NAME OF FATHER: William Jurgerson

11 BIRTHPLACE OF FATHER (city or town):

(State or country): v d

12 MAIDEN NAME OF MOTHER: Roberta Jones

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): v d

14 Informant: nannie Sellers

(Address) 1072 W fairmont ave

15 Filed ..... 19 ..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): January 31 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 4, 1927, to Jan 31, 1927, that I last saw h[illegible] alive on Jan 29, 1927, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Neuritis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H McCard M. D.

2-5, 1927 (Address) 2005 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Calvary Cemetery — Date of Burial 2/4 1927

20 UNDERTAKER: John H Jodnin — ADDRESS 1027 Druid Hill Ave

4 1927 C. HARRISON JONES, M. D. Registrar

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

18646

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 18646

REGISTERED NO. 12-53

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Roland Park

CITY OF BALTIMORE: (No. Roland Ave abov Belvidere ST. WARD

2-FULL NAME Catherine McCormick

(a) RESIDENCE NO. Roland ave abov Belvidere ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No

6 DATE OF BIRTH (month, day, and year) Sept 22nd 1852

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 74 | 4 | 10 11 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Francis McCormick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Anne Cunningham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Edward L Thompson

(Address) Roland Ave near c Gorsuch Balto

15 Filed FEB 4 1927 C. HARRISON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 2 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 23 1927 to Feb. 2 1927

that I last saw her alive on Feb. 1 1927

and that death occurred, on the date stated above, at 12-45A. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficency

due to Chronic Myocarditis

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs.

(Signed) W. Gibson Porter, M. D.

2-3 1927 (Address) 422 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL Feb 5 1927

20 UNDERTAKER Henry H Jenkins Sons Co.

ADDRESS McCulloh & Eutaw Sts

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

18647

## CERTIFICATE OF DEATH.

E 18647

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 13-54 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Ella Greenblatt

(a) RESIDENCE NO. 2407 Linden Ave. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? 37 yrs. — mos. — ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jonas

6 DATE OF BIRTH (month, day, and year) 1863

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| 63 | 63 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 03

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER Abraham Israel

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Rivka Nik

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Jonas Greenblatt

(Address) 2407 Linden Ave

15 FEB 4 1927 C. HARRISON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Feb. 3, 1927

17:

I HEREBY CERTIFY, That I attended deceased from 2 1 1927 to 2 3, 1927, that I last saw h.. alive on 2 3, 1927, and that death occurred, on the date stated above, at 11.15 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage duration

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

Pneumonia (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Emanuel Epstein, M. D.

2/3, 1927 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Southern Ave. Date of Burial 2/4 1927

20 UNDERTAKER Sol Levinson & Bro ADDRESS 1127 E Balto St

Be very important. See instructions on back of cer...

Spec.-7-17-26—A Co.—200 Bks.

E 18648

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 18648

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. 26-36

City of BALTIMORE: (No. 370 St. Helena Ave St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W. Buchholz

(a) RESIDENCE NO. 370 St. Helena Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | White | single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 15, 1926

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min.. |
|---|---|---|---|---|
| | | 3 | 17 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto City

(State or country)

PARENTS

10 NAME OF FATHER Joseph Buchholz

11 BIRTHPLACE OF FATHER (City or town) Balto.

(State or country) Md

12 MAIDEN NAME OF MOTHER Anna Lawley

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md

14 Informant Joseph Buchholz

(Address) 370 St Helena Ave

15 Filed ..... 19 ..... Registrar

R - 4 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 Feb 2 - 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 28, 1927, to Feb 3 1927.

that I last saw h alive on Feb 2 1927.

and that death occurred, on the date stated above, at 4 am

The CAUSE OF DEATH* was as follows:

Bronchopneumonia.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. McCarmine M. D.

2/3 1927 (Address) Dundalk, md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Holy Redeemer Cem | Feb 4 1927 |
| 20 UNDERTAKER | ADDRESS |
| Lilly & Zeiler - co | 403 S. Wolfe |

very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18649

## CERTIFICATE OF DEATH.

101-001

E 18649

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1105 Berkley St. 11-24 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Holly

(a) RESIDENCE. No. 1105 Berkley St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | Colored | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henrietta Holly

6 DATE OF BIRTH (month, day, and year) Jan 5, 1859

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 68 | | 25 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer contracting

(b) General nature of industry, business, or establishment in which employed (or employer) Eckroe, Company

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St. Marys Co. Md.

PARENTS

10 NAME OF FATHER Charles Holly, Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) St. Marys Co. Md

12 MAIDEN NAME OF MOTHER Theresa Fountain

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St. Marys Co. Md

14 Informant Henrietta Holly (Address) 1105 Berkley St

15 Filed FEB - 4 1927 H. [illegible] Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 - 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 31, 1927, to July 2, 1927.

that I last saw h[illegible] alive on Jan 31, 1927.

and that death occurred, on the date stated above, at 1.50 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) None known

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Chas. J. Kelly, M. D.

7/5, 1927 (Address) 200 W. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Mt. Zion Cemetery | Feb. 5, 1927 |
| 20 UNDERTAKER Mrs. Kate R. Williams | ADDRESS 332 N Schroeder St |

Spec.–7-17-26–A Co.—200 Bks.

Dr Forbes 1114 Hanford Rd

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 18650 (top) 90 E 18650 REGISTERED NO.

E 18650

1-PLACE OF DEATH

City of BALTIMORE: (No. 1336 Aisquith St., 9-18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel H Preston Sr.

(a) RESIDENCE NO. 1336 Aisquith St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W. | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Preston

6 DATE OF BIRTH (month, day, and year) 1853

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min.. |
|---|---|---|---|---|
| | 73 | 11 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stone Cutter, retired

(b) General nature of industry, business, or establishment in which employed (or employer) self 015

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Thomas Preston

11 BIRTHPLACE OF FATHER (City or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Emma Read

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Wm H Preston (Address) 335 E Green St

15 Filed FEB 4 1927 C. HARRY JAMES M. D. Registrar By RR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 3 1927 to ..... 19....., that I last saw him alive on Feb 3 1927, and that death occurred, on the date stated above, at 8.45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Arterio Sclerosis

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) L McC Baker, M. D.

2/4, 1927 (Address) 1114 Hanford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Date of Burial Feb 5 1927

20 UNDERTAKER W. E. Cook ADDRESS 502 E Monument

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

Dr Hennessy

# HEALTH DEPARTMENT—CITY OF BALTIMORE

128

## CERTIFICATE OF DEATH

E 18651

E 18651

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2828 Edmondson Ave St., 16-69 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry S Culbertson

(a) RESIDENCE NO. 2828 Edmondson Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Francis M Culbertson

6 DATE OF BIRTH (month, day, and year): Jan 20, 1871

7 AGE: Years 56 Months Days 12 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Watchman 162

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Govt. Chemical Co

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Isaac Culbertson

11 BIRTHPLACE OF FATHER (City or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Georgianna Stone

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant: Francis M Culbertson

(Address): 1030 Hampton Road

Filed FEB 4 1927 19

C. HARRISON JONES, M.D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 2 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 26, 1927, to Feb. 2, 1927, that I last saw him alive on Feb. 2, 1927, and that death occurred, on the data stated above, at 7:10 P m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) uremia other history

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. F. Hennessy, M. D.

(Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet

Date of Burial: Feb. 5 1927

20 UNDERTAKER: Wm Cook

ADDRESS: 600 E North Ave

very important. See instructions on back of certificates.

Spec. -7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18652

## CERTIFICATE OF DEATH

74001

E 18652

1-PLACE OF DEATH Green 13-59

City of BALTIMORE: (No. 2201 Orme Ave St. Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John F Kane

(a) RESIDENCE NO. 2201 Orme Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Jancobina Kane

6 DATE OF BIRTH (month, day, and year) apr 12 - 1856

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min.. |
|---|---|---|---|---|
| | 70 | 9 | 20 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Construction Foreman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: 1886

9 BIRTHPLACE (city or town)

(State or country) Baltimore

PARENTS

10 NAME OF FATHER Mathews Kane

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Baltimore

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant John F Kane Son

(Address) 3 Williams Ave Overlea

15 Filed FEB - 4 1927 C. HAMPSON JONES, M. D. Registrar

By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 1, 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 25th, 1927, to February 1st, 1927, that I last saw him alive on February 1st, 1927, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Coma.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Amelia E. Link, M. D.

2/2nd, 1927 (Address) 1717 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| New Cathedral Cemetery | Feb 5 1927 |
| 20 UNDERTAKER Robt G Turner Sr | ADDRESS N. Broadway |

of certificates. See instructions on back of certificate. very important.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

11-001

E 18653

## CERTIFICATE OF DEATH

REGISTERED NO. E 18653

E 18653

1-PLACE OF DEATH

City of BALTIMORE. (No.) 3536 E. Fairmount Ave (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Schroeder

(a) RESIDENCE NO. 3536 E. Fairmount ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Martha Schroeder

6 DATE OF BIRTH (month, day, and year): Feb 18 1864

7 AGE: Years 62 Months 11 Days 15

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): Self 015

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Christoph Schroeder

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Louisa Schneider

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Martha Schroeder 3536 E. Fairmount Ave

15 Filed FEB - 4 1927 19 C. HARRY JONES, M. D. Registrar. Per RC

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 2-1-27

17 I HEREBY CERTIFY, That I attended deceased from 1-29 19 27 to 2-1 19 27

that I last saw him alive on 2-1 19 27

and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH was as follows*

La Grippe

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos 3 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs

(Signed) J. Thos. Bulger M. D.

(Address) 8004 Bulger Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem. Date of Burial 2/4 1927

20 UNDERTAKER: J. J. Nolan ADDRESS 306 E Baltimore.

Keep this certificate clean and free from folds. See instructions on back of certificates. very important.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18654 58-001 E 18654

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1725 Friendsbury ST. 15-21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Meister

(a) RESIDENCE No. 1725 Friendsbury ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ernest V. Meister

6 DATE OF BIRTH (month, day, and year): Aug. 5-4-1856

7 AGE: Years 70 Months 5 Days 27 28 If LESS than 1 day, ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 000

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Jacob Griessman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Carrie Balladsaich (Address) 1725 Friendsbury St.

15 Filed 1927 C. HARRISON JONES, M. D. Registrar

For

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 2 1927

17 I HEREBY CERTIFY, That I attended deceased from June 25, 1926, to Feb. 2, 1927.

that I last saw h[e] alive on " " , 1927.

and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH* was as follows:

Pernicious Anaemia

(duration) unknown yrs. mos ds.

CONTRIBUTORY (Secondary) Hypo-Static Pneumonia

(duration) — yrs. — mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Blood

(Signed) Charles C. Conser, M. D.

2-3, 1927 (Address) 1101 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: [illegible] Cem

DATE OF BURIAL: Feb 4 1927

20 UNDERTAKER: John Ullrich

ADDRESS: 2[illegible] E Fayette

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18655

## CERTIFICATE OF DEATH.

161-001

E 18655

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 113 W Oxford ST. 23-31 WARD)

2-FULL NAME Teresa Jane Ellis

(a) RESIDENCE NO. 113 W Oxford ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feby 3 -

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | | | | 5 hrs. |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Edw C Ellis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Agnes Pearcy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant Edw C Ellis
(Address) 113 W Oxford

15 Filed FEB - 4 1924 HARRISON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3rd 1924

17 I HEREBY CERTIFY, That I attended deceased from ——, 19—, to ——, 19—, that I last saw h[illegible] alive on Feb 3rd 1924, and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Premature Birth (6½ mos)

(duration) — yrs. — mos 5½ hrs

CONTRIBUTORY (Secondary) (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr. Heibel M. D.

2/3, 1924 (Address) 1224-26 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet Cemetery

DATE OF BURIAL Feby 5 1924

20 UNDERTAKER [illegible]

ADDRESS 2nd & Aisquith

TION is very important. See instructions on back

Simone.

Spec.—12-9-25—A Co.—200 Bks.

E 18656

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

## CERTIFICATE OF DEATH.

E 18656

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. ) St. 21-29 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Simons

(a) RESIDENCE NO. 785 Saint Peter St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1847

| 7 AGE | Years | Months | Days | IF LESS than 1 day ...hrs. or ...min. |
|---|---|---|---|---|
| | 80 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER William Simons

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant

(Address) Records

15 Filed ... 19... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 3 1927

17 I HEREBY CERTIFY, That I attended deceased from December 31 1926, to February 3, 1927.

that I last saw him alive on February 2, 1927.

and that death occurred, on the date stated above, at 4:30 A m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Gross & Laboratory

(Signed) R. Hooper Smith, M. D.

Feb 4 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oxford Talbot Co Md Date of Burial 2/5 1927

20 UNDERTAKER Robert Brockerson ADDRESS Baltimore Collins

FEB 4 1927

very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

E 18657

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 ✓ E 18657

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. 76-27 Ward)

2-FULL NAME James B. Davies

(a) RESIDENCE NO. None St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1871

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 56 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER William Davies

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Anna Nicorn

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant Hospital records

(Address)

15 Filed FEB 4 1927, 19____ C. HARTLAND JONES Registrar

10+0—R.L.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 February 4, 1927

17

I HEREBY CERTIFY, That I attended deceased from January 29, 1927, to Feb. 4, 1927, that I last saw him alive on Feb. 4, 1927, and that death occurred, on the date stated above, at 8.15 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) W. E. Gallaun, M. D.

2-4-27, 19 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL Date of Burial 19

20 UNDERTAKER Commissioner Health ADDRESS

FEB 7 1927

Very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18658

100-001

E 18658

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Pronounced dead at Franklin Sq. Hospital

REGISTERED NO.

City of BALTIMORE: (No. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph N. Saulsbury

(a) RESIDENCE NO. 111 N. Gilmor St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 13 1925

7 AGE: Years 1 Months 4 Days 20 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED: (a) Trade, profession or particular kind of work: Infant old

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country) Md

PARENTS

10 NAME OF FATHER: John N. Saulsbury

11 BIRTHPLACE OF FATHER (city or town): Md

(State or country)

12 MAIDEN NAME OF MOTHER: Lena Gardner.

13 BIRTHPLACE OF MOTHER (city or town): Md

(State or country)

14 Informant: John N. Saulsbury

(Address) 111 N. Gilmor St

15 Filed FEB 4 1927 19 Per C. Hall JONES, Jr. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Feb 2nd 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest thereon and from the evidence obtained by said Inquest find that said deceased came to his death on the day stated above.

(Inquest, Autopsy or Inquiry.)

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Signed Thos. D. Morton M. D.

Feb 4-27 Coroner

(Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Pleasant Cemetery Date of Burial Feb. 4 1927

20 UNDERTAKER: Saml. W. Chase & Son ADDRESS 1640 Pulaski

Cor. Instructions on back of certificate very important.

Spec.—1-12-23—M&T—500 Bks.

Margonti.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

18659

## CERTIFICATE OF DEATH.

90 E 18659

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 613 S. Hanover ST. 22-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara Margonti

(a) RESIDENCE NO. 613 S. Hanover ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? 40 yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Margonti

6 DATE OF BIRTH (month, day, and year): May 20 1860

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 66 | 8 | 13 | 10 |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

037

9 BIRTHPLACE (city or town) (State or country): Italy.

PARENTS

10 NAME OF FATHER: John Barbara

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: B. Barbara

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy.

14 Informant: John Margonti

(Address): 613 S. Hanover st.

15 Filed: 8-4 1927

16 C. HAMILTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 3 - 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 2 - 1927, to Feb. 3 - 1927.

that I last saw h[illegible] alive on Feb. 3 - 1927

and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary): Valvular heart disease, Chronic Nephritis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of No.

Was there an autopsy? —

What test confirmed diagnosis? Appearance from Autopsy

(Signed) A. W. Pinto, M. D.

2-4 1927 (Address) 1 West Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cemetery, Md.

DATE OF BURIAL: Feb 5 1927

20 UNDERTAKER: Geo. F. Ruth

ADDRESS: 1735 Harford

Helen Hughes ✓

Spec.—6-9-19—H. P. Co.—1000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18660

E 18660

## CERTIFICATE OF DEATH.

REGISTERED NO. 23

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 421 Edward Ave. ST.; 27-48 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Hughes

(a) RESIDENCE. NO. 421 Edward Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 6 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Female | Black | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Simon Hughes

6 DATE OF BIRTH (month, day, and year) Aug 31 - 1873

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 53 | 6 | 12 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home work

(b) General nature of industry, business, or establishment in which employed (or employer) home Keeping

(c) Name of employer at home Balt. Co. Md

9 BIRTHPLACE (city or town) (State or country) Balto Co. Md

PARENTS

10 NAME OF FATHER Joseph Reynolds

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co. Md

12 MAIDEN NAME OF MOTHER Virginia Stevenson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co Md

14 Informant (Address) Black Garrison City 692 Lenchenwald Balto

15 Filed FEB - 4 1927 J. C. HAMPSON JONES, M.D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 28 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 28, 1927, to Feb 2, 1927,

that I last saw her alive on Jan 1, 1927,

and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Sleeping Sickness

(duration) 4 yrs. 4 mos. 10 ds.

CONTRIBUTORY (Secondary) General debility

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? Date of no

Was there an autopsy? no

What test confirmed diagnosis? Evidence

(Signed) T. O'C Brown, M. D.

1927 (Address) 6010 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Cemetery — DATE OF BURIAL: Feb 5 1927

20 UNDERTAKER: B. Jamieson Mc. Skimmel — ADDRESS: 1645 Eutaw Pl.

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18661

## CERTIFICATE OF DEATH

101-001

E 18661

1-PLACE OF DEATH University Hospital REGISTERED NO. 22-30

City of BALTIMORE: (No. ) St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Kopeland

(a) RESIDENCE NO. 400 1/2 W Camden St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S. if of foreign birth? yrs. mos. da.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) unk.

7 AGE: Years 62 Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Furniture Finisher

(b) General nature of industry, business, or establishment in which employed (or employer) 014

(c) Name of employer

9 BIRTHPLACE (city or town) N.Y.

(State or country)

PARENTS

10 NAME OF FATHER Chas. Kopeland

11 BIRTHPLACE OF FATHER (City or town) N.Y.

(State or country)

12 MAIDEN NAME OF MOTHER Mary Tefken

13 BIRTHPLACE OF MOTHER (city or town) N.Y.

(State or country)

14 Informant University Hospital

(Address)

15 Filed FEB - 4 1927 C. Harrison Jones M.D. Registrar

P. 014

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 Jan 27 - 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 25 19 27 to Jan 27 19 27

that I last saw h in alive on Jan 27 19 27

and that death occurred, on the data stated above, at 1:30 A.M.

The CAUSE OF DEATH* was as follows: Pneumonic Cardio-vascular Disease.

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 1 da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Signs

(Signed) [illegible] M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

UNIVERSITY OF MARYLAND
COMMISSIONER OF HEALTH
FEB 2 1927

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18662

## CERTIFICATE OF DEATH.

E 18662

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 206 N. Bruce ST. 19-27 WARD)

2-FULL NAME Lillian Matthews

(a) RESIDENCE NO. 206 N Bruce ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? yrs. 3 mos. 17 ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | colored | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 18. 1926

| 7 AGE Years | Months | Days | If LESS than 1 day, ... hrs or ... min. |
|---|---|---|---|
| | 3 | 17 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER William Matthews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Carol Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Va

14 Informant Carol Matthews
(Address) 206 N Bruce st

15 4 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 2 1926, to Feb 26 1927,
that I last saw h[er] alive on Feb 26 1927, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia
Emphysema

(duration) ..... yrs. ..... mos 4 ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No What test confirmed diagnosis? Clinical Exam

(Signed) C J Jones M. D.

, 19 (Address) 613 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL 2/5 1927

20 UNDERTAKER Joseph A. Lively

ADDRESS 409 N. Mount street

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

18663

## CERTIFICATE OF DEATH.

100-001

E 18663

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1512 White St., 20-27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Talbot Davis

(a) RESIDENCE NO. 1512 White ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | C | S |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 27, 1926

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | | 6 | 6 7 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Horace Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Aiken Co. S.C.

12 MAIDEN NAME OF MOTHER Eugenia McCullough

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Aiken Co. S.C.

14 Informant Father

(Address)

15 Filed 4 1927, 19 Per — G. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 2, 1927, to Feb. 3, 1927, that I last saw h- alive on Feb. 3, 1927, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Toxemia, Eclamptic

(duration) yrs. mos. 1 ds.

18 Where was disease cntracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. H. Kelly, M. D.

, 19 (Address) 1520 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Zion — DATE OF BURIAL 2/5 1927

20 UNDERTAKER Joseph A. Lively — ADDRESS 409 N. Monument

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18664 ✓ E 18664

## CERTIFICATE OF DEATH.

REGISTERED NO. 75-73

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 302 Patapsco ave ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles W. Baughman,

(a) RESIDENCE NO. 302 Patapsco ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Virginia R. Baughman

6 DATE OF BIRTH (month, day, and year) May 29-1860

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min |
|---|---|---|---|---|
| | 66 | 7 8 | 3 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter 050

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Joseph K. Baughman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Ann E Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) A. A. Co. Md.

14 Informant Virginia R. Baughman (Address) 302 Patapsco ave Balto

15 C. HAMPSON JONES, M. D. Registrar

4 1927 Balto

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 2 1927

17 I HEREBY CERTIFY, That I attended deceased from July 12 1926 to Feb 2 1927

that I last saw h alive on Feb 2 1927

and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Combined Sclerosis of the Spinal Cord - (duration) 6 mos

CONTRIBUTORY (Secondary) Acute Nephritis (duration) uncertain mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Thos. E. Horton, M. D.

Feb 2nd 1927 (Address) Curtis Bay, Balto. Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park cem

DATE OF BURIAL Feb 5 1927

20 UNDERTAKER Zirkler + Zirkler

ADDRESS 1739 E. Eager st

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18665

E 18665

## CERTIFICATE OF DEATH.

REGISTERED NO. 25-15185

1-PLACE OF DEATH

City of BALTIMORE: (No. 21 Way to Mercy St. (If Hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry J Labahn

(a) RESIDENCE NO. 101 E. 4th St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: white

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Minnie G. Labahn

6 DATE OF BIRTH (month, day, and year): Oct 20 1866

7 AGE: Years 60 Months about 3 Days 13 — IF LESS than 1 day.....hrs. or.....min. 12

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Foreman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Brant Co.

9 BIRTHPLACE (city or town): Balto

(State or country)

PARENTS

10 NAME OF FATHER: Henry Labahn

11 BIRTHPLACE OF FATHER (city or town): Germany

(State or country)

12 MAIDEN NAME OF MOTHER: C. Bothe

13 BIRTHPLACE OF MOTHER (city or town): Germany

(State or country)

14 Informant: Mrs Kohl

(Address) 520 S. Ct. St. Balto

15 Filed: Feb. 3 1927 C. HARTMAN JONES, M. D. Registrar

4 1927 P— RCH

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): February 2-27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock - traumatic

Fract. comp. com. r. leg both bones

Fract left ankle (duration) yrs. mos. ds.

CONTRIBUTORY Caused by a accidentally

Falling from derrick at Curtis Bay

(duration) yrs. mos. ds.

(Signed) (Coroner) M. D.

Feb. 3, 1927 (Address) 108 E Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Olivet Cemetery — Date of Burial: Feb 5 1927

20 UNDERTAKER: John F. Denny — ADDRESS: 715 Light St

very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18666 E 18666

## CERTIFICATE OF DEATH

46

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 2516 Fleet St. 1-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie C. Reitz

(a) RESIDENCE NO. 2516 Fleet St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Reitz

6 DATE OF BIRTH (month, day, and year) Dec. 28 1871

| 7 AGE | Years | Months | Days | IF LESS than 1 day ...hrs. or ...min.. |
|---|---|---|---|---|
| | 55 | 1 | 5 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Frederick J. Smith

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Bertha Weismiller

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant Mamie Peters

(Address) 2516 Fleet St.

4 1927 C. HAMPSON JONES, M. D. Registrar

By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 3 1927

17 I HEREBY CERTIFY, That I attended deceased from October 19, 1926, to February 3, 1927, that I last saw her alive on February 2, 1927, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uterus

(duration) yrs. 3 mos. 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Caleb N. Athey, M. D.

Feb 4 1927 (Address) 100 S Pollerson Parkway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| St Matthews Cemetery | Feb. 7. 1927 |
| 20 UNDERTAKER | ADDRESS |
| Henry Sander & Sons Inc | 1716 Fleet St |

very important. See instructions on back of certificates.

Spec.—12-9-25—A G 2—200 Bks.

18946 2

E 18667

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 18667

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Bailey

(a) RESIDENCE NO. Waterbury P.O. St. Pa Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | married. |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anne

6 DATE OF BIRTH (month, day, and year) 1868

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 59 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Pa.

PARENTS

10 NAME OF FATHER Joshua Bailey

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maine

12 MAIDEN NAME OF MOTHER Susan Thompson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maine

14 Informant Records -

(Address) JOHNS HOPKINS HOSP

4 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 Feb 3

17 I HEREBY CERTIFY, That I attended deceased from Jan 21, 1927, to Feb 3, 1927, that I last saw h.. alive on Feb 3, 1927, and that death occurred, on the date stated above, at 11.45 a.m.

The CAUSE OF DEATH* was as follows:

Brain Tumor — (Surgical)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of 2/1/27.

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) George G. Finney, M. D.

Feb 4, 1927 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lowellville Pa — Date of Burial Feby 8 1927

20 UNDERTAKER John Emrich — ADDRESS 208 Orleans

very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18668

## CERTIFICATE OF DEATH.

129 E 18668

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1626 E Biddle St., 8-13 Ward)

2-FULL NAME Benjamin F. Heaps

(a) RESIDENCE NO. 1626 E Biddle St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Belle I. Heaps

6 DATE OF BIRTH (month, day, and year) July 6-1849

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 77 | 6 | 28 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): 015

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. City

(State or country) Md.

PARENTS

10 NAME OF FATHER Benjamin Heaps

11 BIRTHPLACE OF FATHER (city or town)

(State or country) England

12 MAIDEN NAME OF MOTHER Elizabeth Hinkle

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Belle I. Heaps

(Address) 1626 E. Biddle St.

C. HAMPSON JONES, M. D.

4 1927 P— A.S.E. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 Feb. 3d

17 I HEREBY CERTIFY, That I attended deceased from Dec 1st 1926, to Feb 3d 1927, that I last saw h[illegible] alive on Feb. 3d 1927, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage due to Ch. Nephritis + Hypertension

(duration) yrs. 2 mos. 2 ds.

CONTRIBUTORY (Secondary) Ch. Nephritis

(duration) unknown yrs. mos. ds.

18 Where was disease contracted

If not at place of death!

Did an operation precede death! No Date of

Was there an autopsy! No

What test confirmed diagnosis! —

(Signed) Jeffersonian Assoc. M.D.

3/3 1927 Address 2544 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem. Date of Burial Feb. 5 1927

20 UNDERTAKER Wm. C. Black ADDRESS 927 N. Broadway

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18669

## CERTIFICATE OF DEATH.

66 E 18669

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Northeastern Police Sta. St. 1-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry Myers

(a) RESIDENCE NO. 211 S. Collington Ave St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. — mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 8/1886

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 41 | 0 | 25 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Umbrella Mender

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Frank Myers

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto., Md

12 MAIDEN NAME OF MOTHER Anna Tolson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto., Md.

14 Informant Mrs. Nolan (mother)

(Address) 211 S. Collington Ave

15 Filed [illegible] BALTO. [illegible] Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 2/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to H.S death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac (Myocardial Insufficiency

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Alcoholism

(duration) ....yrs. ....mos. ....ds.

(Signed) [signature] M. D.

(Coroner)

2/3/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State. ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Date of Burial Feb 1927

20 UNDERTAKER Wendell J. Keppel ADDRESS 300 E. Eden St

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18670 E 18670

## CERTIFICATE OF DEATH.

21

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 660 W Baltimore St., (Ward) 4-25

2-FULL NAME Victoria Duvall,

(a) RESIDENCE NO. 660 W Baltimore St. ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Thomas J. Duvall,

6 DATE OF BIRTH (month, day, and year) Nov. I5, I927

| 7 AGE Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|
| 8I | 2 | I9 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Loyd D. Warfield,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Howard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. R. L. Smith, (Address) I32 W Milton Ave.

15 4 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 31 .1927. to Feb 3 .1927.

that I last saw her alive on Feb 3 .1927.

and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Erysipelas left leg.

(duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) John A. Buchanan, M. D.

2/4, 1927 (Address) 375 Stockton St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery — DATE OF BURIAL Feb. 5 1927

20 UNDERTAKER Harry A. Welsh 10-31 W Lanvale — ADDRESS

TION IS very important.

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18671 | CERTIFICATE OF DEATH. | 129E 18671

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1934 Wilkens Ave., ST. 26-28 (WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ann Speers,

(a) RESIDENCE NO. 1934 Wilkens Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ruben I. Speers

6 DATE OF BIRTH (month, day, and year) Oct. 25, 1879

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 47 | 3 | 9 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 037

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Andrew Sporer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER KinngunulaArnold

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant (Address) Ruben I. Speers, 1934 Wilkens Ave.

15 4 1927 C. HAMPSON JONES, M. D. Registrar.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1927, to Feb 3, 1927, that I last saw h alive on Feb 3, 1927, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) T. H. Lamerick M. D.

Feb 4, 1927 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery | DATE OF BURIAL 2/5 1927

20 UNDERTAKER Harry A. Wilhelm | ADDRESS 1031 W Lanvale

For ——— Asst. ———

Spec.—12-9-53 A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

1995 53 E 18672

11-001 E 18672

## CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 70-71 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth King

(a) RESIDENCE NO. 3818 Connecticut Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harry C King

6 DATE OF BIRTH (month, day, and year): 1-21-04

7 AGE: Years 23 Months 0 Days 12 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: N. Tr. 37

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Ind.

PARENTS

10 NAME OF FATHER: Emory Spencer

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Ind -

12 MAIDEN NAME OF MOTHER: Anne Yorker

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Wash. D.C.

14 Informant: Records -

(Address)

15 Filed 5 1927 C. HARRISON JONES, M. D. Registrar

By RRN

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 Feb. 3rd

17 I HEREBY CERTIFY, That I attended deceased from Jan. 14, 1927 to Feb 3, 1927, that I last saw her alive on Feb 3, 1927, and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH* was as follows:

Influenza Pneumonia

(duration) — yrs. — mos. 13 ds.

CONTRIBUTORY (Secondary): None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home in Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Bacteriological

(Signed) Warfield M. Firor, M. D.

2/3, 1927 (Address) 9 W Mt.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — Date of Burial: Feb 7, 1927

20 UNDERTAKER: Chenoweth & Son — ADDRESS: 3617 Chestnut ave

very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 18673

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18673

## CERTIFICATE OF DEATH.

REGISTERED NO. 1001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3630 Cedar Ave (WARD) 13-52

2-FULL NAME Thelma Ruth Harris

(a) RESIDENCE. No. 3630 Cedar Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| F | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Sept 13 1926

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | | 4 | 20 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ind

PARENTS

10 NAME OF FATHER Theodore R Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Catherine Echenrode

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant T. R Harris
(Address) 3630 Cedar Ave

15 Filed 5 1927 19 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 30, 1927, to Feb 3, 1927, that I last saw h[illegible] alive on " 2, 1927, and that death occurred, on the date stated above, at 1.30 PM.

The CAUSE OF DEATH* was as follows:

Broncal Pneumonia

(duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. C Hearn, M. D.

2/7, 1927 (Address) 3401 Fairmount Ave

*Give the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Woodlawn — Feb 5 1927

20 UNDERTAKER — ADDRESS 361

Chenowith & Son — Chestnut 126

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18674

E 18674

## CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

City of BALTIMORE: (No. Redwood & Sar) St. 9-45 (Ward)

2-FULL NAME Frank Robinson

(a) RESIDENCE NO. 2114 Lake Ave St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | white | Married |

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE~~ Sarah Ellenor Robinson

6 DATE OF BIRTH (month, day, and year) February 11th 1867

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 59 | 11 | 23 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chief W. S man Coml

(b) General nature of industry, business, or establishment in which employed (or employer) Agr.

(c) Name of employer W. S. Talbot Co

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER Chas Robinson

11 BIRTHPLACE OF FATHER (city or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Eliz White

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant S. E. Robinson

(Address) 2114 Lake ave

15 1927 C. HARRISON JONES, M. D.

Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3. 27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Valv Disease Heart

Duration (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Duration yrs. mos. ds.

Feb 4 (Signed) W. G. Riley M. D.

, 1927 (Address) 1077 Bway (Coroner)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

Date of Burial Feby 7th 1927

ADDRESS

20 UNDERTAKER George Schilling & Sons 1126 Eutaw st

very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 18675

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18675

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hospital 25-7 Ward)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm B. Mitchell

(a) RESIDENCE NO. 1401 Curtis ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Divorced |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 14, 1865

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 61 | 7 | 20 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) 062

(c) Name of employer —

9 BIRTHPLACE (city or town)

(State or country) Maryland.

PARENTS

10 NAME OF FATHER Wm. Mitchell

11 BIRTHPLACE OF FATHER (City or town)

(State or country) N. C.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) "

(State or country)

14 Informant Mrs. Fottie Adey

(Address) 328 S. 15th. C

5-1927 C. HARRISON JONES M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

2-7-27

17 I HEREBY CERTIFY, That I attended deceased from 2-4, 1927, to 2-4, 1927,

that I last saw him alive on 2-4, 1927,

and that death occurred, on the date stated above, at 7 0 m.

The CAUSE OF DEATH* was as follows:

Acute Bronchopneumonia

Morbus

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. 3 mos ds.

18 Where was disease contracted

if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab.

(Signed) J. Bulla M. D. M. D.

2/5, 1927 (Address) 1122 N Mount St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem — Date of Burial Feb. 7 1927

20 UNDERTAKER Margaret D. Flynn — ADDRESS 1422 Light

- very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 18676

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18676

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. _____ St., 11-24 Ward) REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Davis

(a) RESIDENCE NO. 1033 Druid Hill Ave St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | Negro | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1906

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 21 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Maryland

PARENTS

10 NAME OF FATHER Edward H. Davis

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Calle —

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Maryland

14 Informant _____

(Address) Records

15 Filed _____ 19 _____ Registrar

C. HAMPSON JONES

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 2 1927

17

I HEREBY CERTIFY, That I attended deceased from January 19, 1927, to February 2, 1927, that I last saw him alive on February 2, 1927, and that death occurred, on the date stated above, at 12.45 P m.

The CAUSE OF DEATH* was as follows:

Paratyphoid Fever A.

Intestinal Perforation — ½ hr.

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Generalized peritonitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? yes Date of 1-31-27

Was there an autopsy? no

What test confirmed diagnosis? general & laboratory

(Signed) R. Hooper Smith, M. D.

Feb 2 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Lebanon Dec 5 1927

20 UNDERTAKER Emmert Hensley & Biddle ADDRESS 578

very important. See instructions on BACK of certificate.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18677

## CERTIFICATE OF DEATH.

38 E 18677

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 17-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Penn

(a) RESIDENCE NO. 518 W. Biddle St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | Col | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rena Penn

6 DATE OF BIRTH (month, day, and year) 1886

| 7 AGE 41 | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 39 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of Indnstry, business, or establishment in which employed (or employer) 0/0

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) N. C.

PARENTS

10 NAME OF FATHER Patrick Penn

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) N. C.

12 MAIDEN NAME OF MOTHER Sarah Reid

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) N. C.

14 Informant Reeds

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Registrar

- 5 1927 - RPH

very important. See instructions on back of certificate.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3rd 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan 25 1927 to Feb 3 1927

that I last saw h__ alive on Feb 3 1927,

and that death occurred, on the date stated above, at 11 1/2 a m.

The CAUSE OF DEATH* was as follows:

Syphilis Luetic Myocarditis

Aortitis. Myocardial insufficiency

(duration) 1 yrs. 6 mos. ____ ds.

CONTRIBUTORY (Secondary) none

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? no Date of _____

Was there an autopsy? yes

What test confirmed diagnosis? autopsy.

(Signed) Christopher Johnston, M. D.

, 19 (Address) Johns Hopkin Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dated Burial 2/3 27

Mt. Auburn Cem

20 UNDERTAKER Samuel Wesley McBride ADDRESS 578

Spec—12-23-21—E.B.R.S.—400 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18678 — 001 — E 18678

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. 101

City of BALTIMORE: (No.) 434 (St.) Waverley (Ward) 12-19

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hamuth Hagan

(a) Residence No. 434 (St.) Waverley (Ward)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Fe

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced, (Write the word.) Marr

5a-If married, widowed, or divorced HUSBAND of (or) WIFE Samuel Hamm

6-DATE OF BIRTH (month, day and year) 1872

7-AGE. 55 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. General housework

(b) General nature of industry, business, or establishment in which employed (or employer). —

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS

10-NAME OF FATHER, John Randall

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Samuel Hamm (Address) 434 Waverley St.

15- Filed [illegible] 192 C. HAMPSON JONES M.D. Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 3, 1927

17- I HEREBY CERTIFY, That I attended deceased from Jan 15 1927 to Dec. 2 1927 that I last saw h[illegible] alive on Dec 2 1927 and that death occurred on the date stated above, at 5-4 m. The CAUSE OF DEATH* was as follows:

Bronchitis

(Duration) yrs. mos. 19 ds

CONTRIBUTORY (Secondary) Lobar Pneumonia

(Durution) yrs. mos. 6 ds

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Ex -

(Signed) P. Garland Upshur M. D.

Dec 3 19 (Address) 1334 - Cont Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Calvary — DATE OF BURIAL. 12/6/27 19

20-UNDERTAKER. Mrs P.A. Elliott — ADDRESS 1725 Ashland Ave

Spec.—12-9-25—A Co.—200 Bks.

E 18679

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18679

## CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. (No.) 76-1 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Aiken

(a) RESIDENCE NO. 911 S. Second st. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | Colored | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1889?

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 38 ? | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Georgia

PARENTS

10 NAME OF FATHER John Reed

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Georgia

12 MAIDEN NAME OF MOTHER Rosanna ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Georgia

14 Informant Hospital Records

(Address)

15 Filed_____, 19____ Registrar

very important. See instructions on back of certificate.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

February 4, 1927

17

I HEREBY CERTIFY, That I attended deceased from January 21, 19 27, to February 4, 19 27, that I last saw h.er alive on February 4, 19 27, and that death occurred, on the date stated above, at 1 A.M. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous Peritonitis

Tuberculous Meningitis

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. E. Gatlin, M. D.

2-4-27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Mount Calvary 2/5/27

20 UNDERTAKER ADDRESS

Mrs. R. G. Elbert 1125 Oakland

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1 E 18680 (3) 31 E 18680

REGISTERED NO. _____

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 7-13 Ward)

2-FULL NAME Ruth Marshall

(a) RESIDENCE NO. 943 N. Wolfe St. Balto. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 1925

7 AGE: Years 1 | Months 3 | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Thomas Marshall

11 BIRTHPLACE OF FATHER (city or town)

(State or country) North Carolina

12 MAIDEN NAME OF MOTHER Edmonia Bradford

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) North Carolina

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ....., 19 ..... Registrar

E. E. [illegible] Registrar

DKB

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 Feb. 3

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1st, 1927, to Feb 3, 1927, that I last saw h[illegible] alive on Feb 3, 1927, and that death occurred, on the date stated above, at 4:45 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis

(duration) ..... yrs. ..... mos. 11 ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis

(duration) ..... yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death? 943 N. Wolfe St.

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) H. E. Handley, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvary — Date of Burial: 2/5/27

20 UNDERTAKER: Mrs R. G. Elliott — ADDRESS 1705 Oakland

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18681 | CERTIFICATE OF DEATH. | 29 E 18681

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2422 Ellery ST. WARD) 13-59

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Adams Matthews

(a) RESIDENCE NO. 2422 Ellery ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Joseph Adams & Charles Matthews

6 DATE OF BIRTH (month, day, and year): Oct 7, 1854

7 AGE — Years: 72 — Months: 4 — Days: 1 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Charles Co Md

PARENTS

10 NAME OF FATHER: Christopher C Blair

11 BIRTHPLACE OF FATHER (city or town) (State or country): Charles Co Md

12 MAIDEN NAME OF MOTHER: Mary Ann Sherriff

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Charles Co Md.

14 Informant (Address): Mary F. Adams 2422 Ellery st

15 5 1927 — C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 3 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 24, 1926 to Feb 3, 1927.

that I last saw h alive on Feb 2, 1927

and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

021 Intestinal Nephritis (duration) 2 yrs. 4 mos. ds.

Chronic

CONTRIBUTORY (Secondary) Age & Arteriosclerosis (duration) 2 yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

(Was there an autopsy?) no

What test confirmed diagnosis? Symptoms

(Signed) Thos. H. Wright, M. D.

Feb 4, 1927 (Address) 1209 Presbury

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: Feb 7 1927

20 UNDERTAKER: W. Grimes Corse Inc: — ADDRESS 1203 Pennsylvania Ave

TION is very important. See instructions on back of

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18682

## CERTIFICATE OF DEATH.

90 E 18682

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) Aged. Home St., 19-27 Ward)

2-FULL NAME Babe S. Cottier

(a) RESIDENCE NO. 1400 Lexington St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | Wh | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 1, 1844

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 83 | 1 | 4 3 | |

8 OCCUPATION OF DECEASED None

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Carroll Co Md

PARENTS

10 NAME OF FATHER Peter K. Cottier

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Carroll Co Md

12 MAIDEN NAME OF MOTHER Mary Lents

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Carroll Co Md

14 Informant Ada L. Jones

(Address) 1410 W Lexington St

FEB - 5 1927 C. HAMPSON JONES, M. D.

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 4/27 19

17

I HEREBY CERTIFY, That I attended deceased from Jan 20 1927, to Feb 3 1927,

that I last saw h..... alive on Feb 3 1927,

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. H. [illegible], M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem Date of Burial Feb 5 1927

20 UNDERTAKER George J Smith ADDRESS Holliday

very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 18683

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18683

## CERTIFICATE OF DEATH.

90

15-67

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Riviera Apts. 4 E ST. WARD)

2-FULL NAME Jeannette Oettinger

(a) RESIDENCE NO. Riviera Apts. 4 E ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced
HUSBAND of (or) WIFE Henry Oettinger

6 DATE OF BIRTH (month, day, and year) Nov. 8, 1841

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min |
|---|---|---|---|---|
| | 85 | 10 | 20 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Jacob Weil

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Leila P Flanlaudes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Miss. Oettinger

(Address) Riviera Apts.

15 FEB 5 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/3/1927.

17 I HEREBY CERTIFY That I attended deceased from January 28. 1927. to February 3. 1927. that I last saw her alive on February 3. 1927. and that death occurred, on the date stated above, at P.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis - myocarditis.

Symptoms (duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Hemorrhoids (diarrhoea)

(duration) — yrs. — mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Louis P Hamburger, M. D.

Feb. 1927 (Address) 1207 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ohab Shalom Cem.

DATE OF BURIAL 2/6/27

20 UNDERTAKER Hurd Londheim

ADDRESS 110-20 W. Mt. Royal Ave.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18684

## CERTIFICATE OF DEATH.

101-001

E 18684

1-PLACE OF DEATH

City of BALTIMORE: (No. 227 N Dallas St St. 6-9 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Etha Dumas

(a) RESIDENCE NO. 227 N. Dallas St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | col | |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Floyd Dumas

6 DATE OF BIRTH (month, day, and year): Unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 32 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Balto. Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town):

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country)

14 Informant: Police Dept.

(Address) C. HARRISON JONES, M. D.

15 Date: 19 Registrar

5 1927

1111

TO MORGUE.

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 2/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Lobar Pneumonia

(duration) yrs. about mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Gallen M. D.

(Coroner)

2/4/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

JOHNS HOPKINS HOSPITAL

20 UNDERTAKER — ADDRESS

FEB 5 1927

Commissioner Health.

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18685

## CERTIFICATE OF DEATH.

66 E 18685

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

E 18685

1-PLACE OF DEATH

City of BALTIMORE: (No. 227 N. Gilmor St. 16-27 Ward)

2-FULL NAME Elizabeth Poole

(a) RESIDENCE NO. 227 N. Gilmor St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Female | Cold | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| About 55 | | 0 | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

9 BIRTHPLACE (city or town) Va

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Arthur Poole

(Address) 228 N. Gilmor St

15 Filed FEB 5 1927, 19 HAMILTON JONES M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest thereon and from the evidence obtained by Inquest find that said deceased came to her death on the day stated above.

(Inquest, autopsy or inquiry.)

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

Unknown

(duration) 1 mos. ds.

CONTRIBUTORY (Secondary) Heart Failure

(duration) yrs. mos. ds.

(Signed) Thos. B. Horton M. D.

(Coroner)

, 19 (Address) Curtis Bay, Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Johns Hopkins Hospital Date of Burial FEB 5 - 1927, 19

20 UNDERTAKER Commissioner Health ADDRESS

For 27 A. Gilbert

very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

E 18686

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 E 18686

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals (C.H.) St. 5 Ward 8)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Dabney

(a) RESIDENCE NO. 212 Colvin st. St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | Married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1892

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| 35 | 34 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER Wm. Dabney

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Hospital Records

(Address)

5 1927 19 C. HARRISON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 February 3, 1927

17

I HEREBY CERTIFY, That I attended deceased from January 11 27, 19..., to February 3 27, 19...,

that I last saw him alive on February 3, 19 27,

and that death occurred, on the date stated above, at 2.15 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) M. O'Sullivan, M. D.

2-5-27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Farmville Va. Date of Burial Feb 6 1927

20 UNDERTAKER Chas. H. Johnson ADDRESS 416 N. Carolina Ave

Very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 18687

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

31 E 18687

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 917 N Chester St. 9-12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leonard Hroart

(a) RESIDENCE NO. 917 N Chester St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine Hroart

6 DATE OF BIRTH (month, day, and year) Jan 5 - 1853

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|---|
| | 114. | | 28 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laboier

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Anthon Hroart

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Maria Ludwig

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Katherine Hroart

(Address) 917 N Chester St

15 Filed ..... 19 ..... Registrar

5 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 27, 1927, to Feb. 3, 1927, that I last saw h[illegible] alive on Feb. 3, 1927, and that death occurred, on the date stated above, at 9 15 A m.

The CAUSE OF DEATH* was as follows:

Acute Miliary Tuberculosis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum positive TB

(Signed) Joseph Pokorny, M. D.

19 (Address) 2200 E Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dawn Cemetery

Date of Burial Feb 5 1927

20 UNDERTAKER Hoff & Turner

ADDRESS N Broadway

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18688

100-E 18688

## CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 321 S Durham St. 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herbert Angelo

(a) RESIDENCE NO. 321 S Durham St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year) Dec. 11 – 1926

7 AGE Years Months 2 Days 23 1 25

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Dominick Angelo

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Italy

12 MAIDEN NAME OF MOTHER Ella Lane

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore

14 Informant Ella Angelo

(Address) 321 S Durham St

15 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 4 1927

17 I HEREBY CERTIFY, That I attended deceased from 1/21, 1927, to 2/4, 1927

that I last saw h[illegible] alive on 2/3, 1927

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Bronchitis

Bronchopneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Anthrax & Heart failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & symptoms

(Signed) H D Bruce M. D.

, 19 (Address) 1628 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery

Date of Burial: Feb 7 1927

20 UNDERTAKER: Hoff & Turner Co

ADDRESS 1122 N Broadway

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 18689

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18689

## CERTIFICATE OF DEATH.

REGISTERED NO. 2575

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 10 S First ST. Brooklyn WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Violet Irene Arnold

(a) RESIDENCE NO. 10 S. 1st. St., Brooklyn ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | White | Widowed |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of James Arnold, deceased

6 DATE OF BIRTH (month, day, and year) Jan. 17, 1889

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 38 | 0 | 15 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER Joseph W. Marshall

11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)

12 MAIDEN NAME OF MOTHER Rose Byrns

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant Father
(Address) Same

15 Filed 5 1927, 19 C. HARRISON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 2nd. 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan. 28nd. 1927 to Feb. 2nd. 1927

that I last saw h 9r alive on Feb. 2nd. 1927

and that death occurred, on the date stated above, at 8:45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma, stomach.

(duration) - yrs. 4 mos - ds.

CONTRIBUTORY (Secondary) Carcinoma, left breast.

Operation; recovery 1 mos. ago. ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? Yes Date of 1 yr. ago/breast

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Robert Wilson, M. D.

, 19 (Address) Brooklyn

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Cedar Hill Cemetery | 2/5/ 1927 |
| 20 UNDERTAKER E. J. Fanning, Inc. | ADDRESS 1160 Hollins Ave. |

TION is very important

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

18690 E 18690

## CERTIFICATE OF DEATH.

18690

REGISTERED NO. 21-31 31v

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1116 Warner St., WARD)

2-FULL NAME James Andrew Brown

(a) RESIDENCE NO. 1116 Warner ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1½ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | colored | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 16-1910

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or ... min. |
|---|---|---|---|---|
| | 17 | 0 | 17 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Day Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Fairfield S. C.

PARENTS

10 NAME OF FATHER Henry Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Henrietta Sanders

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Henry Brown (Address) 1116 Warner St.

5 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 3 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 25. 1927. to Feb 3. 1927.

that I last saw him alive on Feb 3. 1927

and that death occurred, on the date stated above, at 11.30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ? yrs. ? mos ? ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) D. H. Conner, M. D.

2/3/27 (Address) 20 Chapman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fairfield Wmsboro Co. S. C.

DATE OF BURIAL 2-5 1927

20 UNDERTAKER John N. Goodwin

ADDRESS 1927 Hand Hill

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18691

## CERTIFICATE OF DEATH.

25-76 179

E 18691

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore General Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lucille Grandberry.(C)

(a) RESIDENCE NO. 4th St. Fairfield, St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female. | Colored | Single. |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) March 7, 1921

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 5 | 10 | 25 26 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Atlantic City N. J.

PARENTS

10 NAME OF FATHER David Grandberry.(C)

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Texas.

12 MAIDEN NAME OF MOTHER Inez Carter.(C)

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) South Carolina.

14 Informant Inez Grandberry.(C) mother.
(Address) 4th St. Fairfield.

5 1927 C. HAMPSON JONES, M. D.
By ---
Registrar

very important. See instructions on BACK of Certificate.

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 2, 1927. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns about the body, playing with matches. Toxic absorption.
Occidental death

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) C. H. M. Bernhardt M. D.
(Coroner)

2/5. 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? 4th St. Fairfield. Jany 5, 1927.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvery Date of Burial Feb 6 1927

20 UNDERTAKER Edward Bryan ADDRESS 1681 Orleans St

18692

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18692

## CERTIFICATE OF DEATH.

5-8 90

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E Mills

(Residence in Baltimore: No. 1314 Orleans St.; yrs.....mos.....ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

| 3-SEX. | 4-COLOR OR RACE. | 5-Single, Married, Widowed or Divorced. (Write the word.) |
|---|---|---|
| Female | Colored | Widow |

6-DATE OF BIRTH. unknown (Month) (Day) 1837 (Year)

7-AGE. 90 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) none

9-BIRTHPLACE. (State or Country). Balto City

PARENTS.

10-NAME OF FATHER. unknown

11-BIRTHPLACE OF FATHER. (State or Country). Balto City

12-MAIDEN NAME OF MOTHER. unknown

13-BIRTHPLACE OF MOTHER. (State or Country). Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) mary wadham

(Address) 1314 Orleans

15-

Filed 5 1927 C. HAMPSON JONES, M. D., Registrar.

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 4 1927 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

General arterio sclerosis

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) 2 yrs. mos. ds.

(Signed) James M Rambo M. D. (Coroner.)

2 14 27 192... (Address) 1000 Eutaw

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

1314 Orleans

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Asbury cemetery DATE OF BURIAL. Feb 7 1927

20-UNDERTAKER. Edward Bryan ADDRESS 1681 Orleans st

Spec.-7-17-26—A Co.—200 Bks.

E 18693

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18693

## CERTIFICATE OF DEATH

× 60-001

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. 4-39 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bruce Prichett

(a) RESIDENCE NO. Hillsboro Md. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fm

4 Color or Race: Blad

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Howard Prichett

6 DATE OF BIRTH (month, day, and year): Jan? 1878

7 AGE — Years: 49 — Months: 1 — Days: — IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) .....

(State or country) Va

PARENTS

10 NAME OF FATHER Bruce Palmer Prichett

11 BIRTHPLACE OF FATHER (City or town) .....

(State or country) Va

12 MAIDEN NAME OF MOTHER Martha Clark

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) Md

14 Informant Howard Prichett

(Address) Hillsboro. Md.

5 1927 C. HAMPSON JONES, M. D. Registrar

Per ACR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-4 1927

17 I HEREBY CERTIFY, That I attended deceased from 12/24, 1926 to 2-4, 1927

that I last saw her alive on 2-4, 1927

and that death occurred, on the data stated above, at 1:30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Thyrotoxicosis

(duration) yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) Toxic adenoma

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 2-3/27

Was there an autopsy? No

What test confirmed diagnosis? Obs. at Hospital & Symptoms.

(Signed) W. C. Lennon, M. D.

, 19 (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hillsboro Md. — Date of Burial: 2/5/27

20 UNDERTAKER: Harry A. Keith — ADDRESS: 1531 W. Fayette St.

very important. See instructions on back of certificates.

Spec.—12-9-25—No.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18694

1927 984

E 18694

## CERTIFICATE OF DEATH.

+ 118-002

E 18694

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 19 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mabel Barberstock

(a) RESIDENCE NO. Punxsutawney, Pa St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced. (write the word): single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): 10-28-02

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 24 | 3 | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Graduate Nurse

(b) General nature of industry, business, or establishment in which employed (or employer): 48

(c) Name of employer: 0

9 BIRTHPLACE (city or town)

(State or country): Pa -

PARENTS

10 NAME OF FATHER: Burton Barberstock

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Pa -

12 MAIDEN NAME OF MOTHER: Edith Painter

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Pa -

14 Informant: Records

(Address): JOHNS HOPKINS HOSPITAL

15 [illegible] 19 H. [illegible] JONES M.D.

FEB 6 1927

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927: Feb 4

17 I HEREBY CERTIFY, That I attended deceased from Oct 23, 1926, to Feb 4, 1927, that I last saw h[illegible] alive on Feb 4, 1927, and that death occurred, on the date stated above, at 11 35 P. m.

The CAUSE OF DEATH* was as follows: Partial intestinal obstruction due to postoperative adhesions

Pt had previous appendectomy - 1916

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary): Pyelitis & pyelonephritis + Peritonitis (terminal)

(duration) yrs. mos. 7 ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? yes Date of Jan 1926

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Warfield M Theobald, M. D.

, 19 (Address) JHH

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Punxsutawney Pa

Date of Burial: Feb 6 1927

20 UNDERTAKER: John O. Mitchell

ADDRESS: 900 Eutaw Place

very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18695 CERTIFICATE OF DEATH E 18695

REGISTERED NO. 139

1-PLACE OF DEATH Howard A. Kelly Hospital Inc

CITY OF BALTIMORE: (No.) 1418 Eutaw Place ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mabel C. Bartlett.

(a) RESIDENCE NO. Warren Pa. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Earl C. Bartlett

6 DATE OF BIRTH (month, day, and year) Nov 8 1876

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or min. |
|---|---|---|---|---|
| | 50 | 2 | 28 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Warren Penna.

PARENTS

10 NAME OF FATHER Francis R. Cogswell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Warren Penna

12 MAIDEN NAME OF MOTHER Mary Louise Keller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Warren Penna

14 Informant Earl C. Bartlett

(Address) Warren Penna

15 FILED FEB - 6 1927 HEALTH DEPT. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5 1927.

17 I HEREBY CERTIFY, That I attended deceased from Jan 28, 1927, to Feb 5, 1927.

that I last saw h[illegible] alive on Feb 5, 1927.

and that death occurred, on the date stated above, at 11.45 a. m.

The CAUSE OF DEATH* was as follows: Gunshot Lacerations

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Myocarditis chronic

(duration) 9 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? Yes Date of Jan 31. 1927

Was there an autopsy? No.

What test confirmed diagnosis? Secondary Suturing

(Signed) Theodore Neal Jr., M. D.

2-5-1927 (Address) 1418 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Warren Penna DATE OF BURIAL Feby 6 1927

20 UNDERTAKER Chas. G. Black ADDRESS 742 W. North ave

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 18696

E 18696

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2107 Orleans St. 6-10 Ward)

2-FULL NAME George J. Wahl Jr

(a) RESIDENCE NO. 2107 Orleans St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? 3 yrs mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male. | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 28 1923

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 3 | 2 | 8 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md.

PARENTS

10 NAME OF FATHER George J Wahl

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Irene E Donnelly

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Balto Md

14 Informant George J Wahl

(Address) 2107 Orleans St

15 Filed 1927 16 C. HAMPSON JONES, M. D. Registrar

B - 6 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

2-5-27

17 I HEREBY CERTIFY, That I attended deceased from 1-28 19 27 to 2-5 19 27

that I last saw him alive on 2-5 19 27

and that death occurred, on the date stated above, at 5:20 P.M.

The CAUSE OF DEATH* was as follows: Pharyngeal Diphtheria

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Carditis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Culture

(Signed) Fred Thumpe M. D.

(Address) 800 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery Date of Burial Feb 6 1927.

20 UNDERTAKER Dan C. Miller Sr ADDRESS 2314 E Fayette St

very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18697

## CERTIFICATE OF DEATH.

6-10

90 E 18697

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 145 N. Curley ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucinda Harmon

(a) RESIDENCE NO. 145 N. Curley ST., ..... WARD Worcester Co. Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles B. Harmon

6 DATE OF BIRTH (month, day, and year) March 1- 1853

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 73 | 11 | 3 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Worcester Co. Md.

PARENTS

10 NAME OF FATHER Wm. Bradford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Mrs. Carrie Mech

(Address) 145 N. Curley St.

15 FEB 6 1927 C. HAMPTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 25, 1927 to Feb. 4, 1927

that I last saw h.... alive on Feb. 4, 1927

and that death occurred, on the date stated above, at 6 45 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) ... yrs. 3 mos ... ds.

CONTRIBUTORY (Secondary) Anemia

(duration) ... yrs. ... mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. W. Herrman M. D.

19 (Address) 919 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Newark, Worcester Co, Md

DATE OF BURIAL Feb 8 1927

UNDERTAKER Zirkler + Zirkler

ADDRESS 1739 E Eager St

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18698 ✓ 94 E 18698

E 18698

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital REGISTERED NO. 1744

CITY OF BALTIMORE: (No. 33 & Calvert St ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jerome Robert Weinstein

(a) RESIDENCE NO. Severn Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | white | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 12, 1926

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 0 | 11 | 22 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Samuel Weinstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Bessie Ashman

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Hospital Records (Address)

15 Filed FEB - 6 1927 H. [illegible] JONES, M. D. Registrar

By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 31, 1927, to Feb 4, 1927, that I last saw him alive on Feb 4, 1927, and that death occurred, on the date stated above, at 7.25 P m.

The CAUSE OF DEATH* was as follows:

B-Streptococcal septicemia

(duration) yrs. mos 6 ds. ?

CONTRIBUTORY (Secondary) cervical adenitis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical & lab. methods

(Signed) Fowler Smith, Jr., M. D.

, 19 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosh Rood

DATE OF BURIAL 2/6 19 27

20 UNDERTAKER Joel Levin

ADDRESS 1439 E Balto St

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 18699 — 129 E 18699

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Hebrew Home for Incurables

CITY OF BALTIMORE, (No.) 2100 E. Baltimore St., (WARD) 7-D

2-FULL NAME Jacob Platskey

(a) RESIDENCE NO. 2100 E. Baltimore St. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Platskey

6 DATE OF BIRTH (month, day, and year) [illegible]

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 87 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work old age

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Platskey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Platskey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Herman Meyer

(Address) 2101 Linden ave

15 Filed 6 1927 H. A. [illegible] Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/4 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov. 23, 1926, to Feb 4, 1927, that I last saw h. alive on Feb 4, 1927, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

a. nephritis

(duration) 2 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

Feb 6 1927 (Address) 1815 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Hebrew Rest

DATE OF BURIAL 2/6 1927

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E Balt St

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 18700

## CERTIFICATE OF DEATH.

REGISTERED NO. E 18700

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St., 7-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Israel Miller

(a) RESIDENCE NO. 1812 Fairmount Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| M | white | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Miller

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 43 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER Nathan Miller

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Levin

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Anna Miller

(Address) 1812 E. Fairmount Ave

Filed FEB - 6 1927 T. HARRISON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/5/ 1927

17 I HEREBY CERTIFY, That I attended deceased from 2/2/27, 19, to 2/5, 19 27, that I last saw him alive on Feb. 5, 19 27, and that death occurred, on the date stated above, at 3.15P m.

The CAUSE OF DEATH* was as follows:

Bronchiectasis

Cardiac hypertrophy & dilatation

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John A. Askin, M. D.

, 19 (Address) Sinai Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Northern Circle Cem. Date of Burial 2/6 1927

20 UNDERTAKER Jack Lewis ADDRESS 1429 E. Balt St

very important. See instructions on back

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18701

## CERTIFICATE OF DEATH.

90

E 18701

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 1405 N. Calhoun St., 15-23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Vernie Blanchard

(a) RESIDENCE NO. 1405 N. Calhoun St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | C | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Workman

6 DATE OF BIRTH (month, day, and year) June 27 1889

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| 37 | 38 | 7 | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Unk.

(State or country) Tennessee

PARENTS

10 NAME OF FATHER James Henderson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Tennessee

12 MAIDEN NAME OF MOTHER Alice Hershel

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Tennessee

14 Informant Arthur Boyd

(Address) 1405 N. Calhoun St.

15 Filed FEB - 6 1927 19 E. A. JONES, M. D. Registrar

very important. See instructions on back of

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 3, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) No History

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D. (Coroner)

Feb. 3, 1927 (Address) 780 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Mount Calvary | 2/6/27 |

| 20 UNDERTAKER | ADDRESS |
|---|---|
| Mrs. P. G. Elliott | 1125 Ashland Ave. |

E 18702

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

27 E 18702

1 PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No 4401—Liberty Hgts Ave St. 26 WARD)

2-FULL NAME Ann. L. Johnson

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 4401—Liberty Hgts Ave St.; yrs. mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS

| 3-SEX | 4-COLOR OR RACE | 5-SINGLE ~~MARRIED~~ WIDOWED ~~OR DIVORCED~~ (~~Write~~ the word) |
|---|---|---|
| F. | W— | widow |

6-DATE OF BIRTH August (Month) 9 (Day), 1842 (Year)

7-AGE 84 yrs. 5 mos. 24 ds. — If LESS than 1 day, ..... hrs., or ..... min.? 26

8-OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): ditto

9-BIRTHPLACE (State or country): England

PARENTS

10-NAME OF FATHER: Dont Know

11-BIRTHPLACE OF FATHER (State or country): Dont Know

12-MAIDEN NAME OF MOTHER: Dont Know

13-BIRTHPLACE OF MOTHER (State or country): Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary L. Osborne

(Address) 4401 Liberty Hgts

15- Filed 6 1927 C. HARTMAN JONES, M. D.

REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Feb— 5th (Month) (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan— 1, 1927, to Feb— 5 1927, that I saw h.r alive on Feb— 3rd 1927, and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

Cirrhosis Liver
Senile degeneration of Brain
(Duration) 5 yrs ... d.
Contributory (SECONDARY) old age—Asthenia
(Duration) ... yrs ... mos. ... ds.

(Signed) Chas Jones M. D.
Feb— 5th 1927 (Address) 7802 Rockspring

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Detroit Mich — DATE OF BURIAL: Feb ..., 1927

20-UNDERTAKER: Josiah Pepper & Co — ADDRESS: North Ave

Spec.—1-10-21—M&T—1500 Bks.

Dunson

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

18703

1927 E 18703

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1211 Edward ST. 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Dunson

(a) RESIDENCE NO. 1211 Edward ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | married |

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Henrietta Dunson

6 DATE OF BIRTH (month, day, and year) Sept 14 1861

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or ..... min. |
|---|---|---|---|---|
| | 65 | 4 | 20 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teamster

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Dunson

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown (State or country)

14 Informant Mrs Henrietta Dunson (Address) 1211 Edward St

15 Filed FEB 6 1927 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 2 1927 to Feb 4 1927, that I last saw him alive on Feb 3 1927, and that death occurred, on the date stated above, at 1.30 P.M.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency
Chronic Pneumonia
and Cardiac Paralysis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R. J. Young M. D.

2/5 1927 (Address) 1429 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Osborn Cemetery | Feb 7 1927 |
| 20 UNDERTAKER | ADDRESS |
| Mrs Mabel D. Bailey | 1421 Hollins |

Spec.—1-10 21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18704

## CERTIFICATE OF DEATH.

12 E 18704

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 912 Bond St. ST., 18-7 WARD)

2-FULL NAME Josephine Jackson

(a) RESIDENCE NO. 912 Bond St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Washington Jackson

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE Years 77 Months 0 Days 0 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gen. Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Labor 037

(c) Name of employer At home

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Jacques Messiah

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) France

14 Informant Lamar Jackson (niece)

(Address) 912 Bond St.

15 Filed 2-6 1927. 19 C. HAMPTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 19, 1927, to Feb 4, 1927.

that I last saw h[illegible] alive on Feb 3, 1927,

and that death occurred, on the date stated above, at 7:30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Bright's

(duration) 1 yrs. 0 mos 0 ds.

CONTRIBUTORY (Secondary) none

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical tests

(Signed) R B Kenyon M. D.

2/6, 1927 (Address) 607 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Peter's Cemetery

DATE OF BURIAL Feb. 7 1927

20 UNDERTAKER Mrs. Katie R. Williams

ADDRESS 322 N. Schroeder St

Spec.—12-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1997 29 E 18705

101-001

REGISTERED NO. E 18705

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 8-12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lloyd L. Smith

3(a) RESIDENCE NO. 2403 E. Biddle St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Sngl.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 16 1926

7 AGE — Years: | Months: 4 | Days: 18 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Balto.

PARENTS

10 NAME OF FATHER W. M. Smith

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Md —

12 MAIDEN NAME OF MOTHER Kate Pritchett

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Md —

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Registrar

FEB 6 1927 U. E. [illegible]

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 Feb. 4

17 I HEREBY CERTIFY, That I attended deceased from Jan. 28, 1927, to Feb. 4, 1927, that I last saw h[illegible] alive on Feb. 4, 1927, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

acute primary pneumonia (lobar)

(duration) .....yrs. .....mos. 9 ds.

CONTRIBUTORY (Secondary) —

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? .....

(Signed) E. C. Jane, M. D.

Feb. 5, 1928 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — Date of Burial: Feb'y 7 1927

20 UNDERTAKER: Henry Hoech & Son — ADDRESS: 1301 E Eager St

very important. See INSTRUCTIONS on BACK of CERTIFICATE

Spec.–7-17-26—A Co.—200 Bks.

E 18706

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

129 E 18706

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1905 Cecil Ave. St. 9-46 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Lange

(a) RESIDENCE NO. 1905 Cecil Ave St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 3 mos. 8 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick H. H. Lange

6 DATE OF BIRTH (month, day, and year): October 27 1857

7 AGE: Years 69 Months 3 Days 8 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, professinn or particular kind of work: None

(h) General nature of industry, business, nr establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER Herman Reichert

11 BIRTHPLACE OF FATHER (City or tnwn) Germany

(State or country)

12 MAIDEN NAME OF MOTHER Katherine Pracht

13 BIRTHPLACE OF MOTHER (city or tnwn) Germany

(State or country)

14 Informant Mrs. John H. Steinz

(Address) 1905 Cecil Ave

15 Filed [illegible] 1927 C. [illegible] JONES, Registrar.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 5th 1927

17 I HEREBY CERTIFY, That I attended deceased from July 6 1923 to Feb. 4 1927

that I last saw h[illegible] alive on Feb. 4 1927

and that death occurred, nn the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

Hypocondriacal Chronic Arthritis

(duratinn) 3 yrs. mns. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 5 yrs. mos. ds.

18 Where was disease cnntracted if nnt at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. P. Fenwick M. D.

, 19 (Address) 12 W. Biddle St

*State the Disease Causing Death, nr in deaths frnm Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — Date of Burial: Febry 8 1927

20 UNDERTAKER: Henry Storch Son — ADDRESS: 1301 E Lafayette

very important. See instructions on back of certificate.

8 - 6 1927 Per RH

Spec. -7-17-26—A Co.—200 Bks.

E 18707

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

48 E 18707

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1701 S. Clinton St. 76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Mary Selig

(a) RESIDENCE NO. 1701 S. Clinton St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S. if of foreign birth? 77 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John F Selig

6 DATE OF BIRTH (month, day, and year) Aug 25-1836

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min.. |
|---|---|---|---|---|
| | 90 | 5 | 8 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Francis Lind

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany.

14 Informant Andrew F Selig

(Address) 1701 S Clinton St

15 FEB - 6 1927

16 C. HARRISON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3 - 1927

17 I HEREBY CERTIFY, That I attended deceased from 1/1/2 19 26 to 2/2 19 27

that I last saw h[illegible] alive on 2/1/27 19

and that death occurred, on the date stated above, at 6 30 a. m.

The CAUSE OF DEATH was as follows:

Arteriosclerosis

Myocarditis

Epithelioma face

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) C. H. Jones M. D.

2/3/27 (Address) 633-5-34

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. Date of Burial Feb. 7 1927

20 UNDERTAKER Lilly and Zeiler ADDRESS 403 S Wolfe St

very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 18708

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

100-001

REGISTERED NO. E 18708

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 804 W. Franklin ST., 12-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Romaine Montague

(a) RESIDENCE NO. 804 W. Franklin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, ~~Married, Widowed, or Divorced~~ (Write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 22 . 1911

7 AGE: 15

| Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|
| 16 | 4 | 11 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: High School Student

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: George Montague

11 BIRTHPLACE OF FATHER (city or town) (State or country): Louisa, Va.

12 MAIDEN NAME OF MOTHER: Ella Hackett

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Louisa Co Va

14 Informant (Address): George Montague 804 W. Franklin St

15 Filed FEB 6 1927 C. FARRINGTON JONES, M.D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 3 — 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 22 , 1926 , to Feb. 3 , 1927 , that I last saw her alive on Feb. 3 , 1927 , and that death occurred, on the date stated above, at 12 A m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) 2 yrs. 2 mos ds.

CONTRIBUTORY (Secondary): Tonsilitis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Symptoms Physical Signs

(Signed) W. H. Thelin M. D.

19 (Address) 1216 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: Feb 7 1927

20 UNDERTAKER: Daniel Carton

ADDRESS: Balto

Spec.—8-24-14—M. & T.—2000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18709

## CERTIFICATE OF DEATH.

101-001

REGISTERED NO. C E 18709

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 405 N Parrish 14-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph H. Keys

(Residence in Baltimore: No. 405 N. Parrish St.; ....yrs., ....mos. ....da.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6-DATE OF BIRTH, Dec 6 (Month) (Day), 1926 (Year)

7-AGE, 3 yrs. 28 mos. 1 da.

If LESS than 1 day, ....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work boy
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Md Baltimore City

PARENTS.

10-NAME OF FATHER Joseph Keys

11-BIRTHPLACE OF FATHER (State or Country), md

12-MAIDEN NAME OF MOTHER Roberta Worden

13-BIRTHPLACE OF MOTHER (State or Country), md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Minnie Keys

(Address) 405 Parrish St

15-

Filed 6 1927 C. HARRISON JONES, M. D. 192..

By ..... Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 2 (Month) 4 (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 2-3-27 191..., to 2-4-27 191...,

that I saw h[illegible] alive on " 191...,

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ....yrs. ....mos. 2 da.

CONTRIBUTORY (Secondary) Expense

(Duration) ....yrs. ....mos. ....da.

(Signed) F. M. Caldwell M. D.

2-5-27, 01... (Address) 1524 Hillsdale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Dr Auburn Cem

DATE OF BURIAL, Feb 8, 192[illegible]

20-UNDERTAKER Dunn Eastes

ADDRESS [illegible] Eas

Spec.—12-9-25—A Co.—200 Bks.

E 18710

# HEALTH DEPARTMENT—CITY OF BALTIMORE

40 E 18710

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

REGISTERED NO.

City of BALTIMORE: (No. [redacted] St. 17-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clifton Mitchell

(a) RESIDENCE NO. 206 Ware Alley St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | Negro | ? |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1906

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 21 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Claude Mitchell

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant BALTIMORE CITY HOSPITALS

(Address [redacted])

15 Filed ..... 19 C. HAMILTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 4 1927

17

I HEREBY CERTIFY, That I attended deceased from April 4 1926, to February 4, 1927, that I last saw him alive on February 4, 1927, and that death occurred, on the date stated above, at 8.40 P m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency
Chronic Myocarditis and
Insufficiency

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? gen'l & laboratory

(Signed) D. Hooper Linell, M. D.

Feb 5, 1927 Address BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem Date of Burial Feb 6 1927

20 UNDERTAKER Hamil Eastern ADDRESS 916 Pa Ave

very important. See instructions on back of certificate

Spec.—1-10-21—M&T—1500 Blks.

18711

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 18711

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 318 Gilmor ST., 14-28 WARD) 31

2-FULL NAME Nellie Mills

(a) RESIDENCE NO. 318 Gilmor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Arthur Mills

6 DATE OF BIRTH (month, day, and year): [illegible]

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 52 | - | - | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: [illegible] Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country): [illegible]

12 MAIDEN NAME OF MOTHER: [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country): [illegible]

14 Informant: George Mills

(Address): 318 Gilmor

15 Filed [illegible] 19 [illegible] C. HAMPSON JONES, M. D. Registrar

B - 6 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2-5- 1927

17

I HEREBY CERTIFY, That I attended deceased from 1-2, 1927 to 2-6-, 1927.

that I last saw h— alive on 2-5-, 1927

and that death occurred, on the date stated above, at 8a m.

The CAUSE OF DEATH* was as follows:

Pulmonary T.B.

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Influenza

(duration) 1 yrs. mos 30 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Richard Dean, M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: 2/8 19 27

20 UNDERTAKER: Le Roy L. Hedges — ADDRESS: 4702 Reisterstown Rd

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

84 E 18712

REGISTERED NO. E 18712

1-PLACE OF DEATH Mercy Hospital

City of BALTIMORE: (No. 4 St., 47 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vera Murphy — 4

(a) RESIDENCE NO. 3603, Greenmount Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years 2 | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED: (a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Balto Md

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country)

14 Informant: Catholic Charities

(Address) 408 Cathedral St.

15 Filed [illegible] 19 C. HARRISON JONES, M. D. Registrar

B-6 1927 Per R.M.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1927, to Feb 4, 1927

that I last saw h[illegible] alive on Feb 4, 1927

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Myotonia Congenitalis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Malnutrition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Jan 25 '27

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) [illegible] M. D.

. 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Date of Burial 2/7 1927

20 UNDERTAKER: [illegible] ADDRESS 1318 Eight St.

very important. See instructions on back of Certificate

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

149713 47 — 44 — E 18713

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Purcell

(a) RESIDENCE NO Forest Pk, Route #3 St. Roanoke Va

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Purcell

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 60 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer —

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town)

(State or country) —

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) —

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

Filed FEB-6 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6 1927.

17

I HEREBY CERTIFY, That I attended deceased from Jan 15, 1927, to Febr. 6, 1927.

that I last saw h.. alive on Feb. 6, 1927

and that death occurred, on the date stated above, at 1284 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. mos. 10 ds.

18 Where was disease contracted Home

If not at place of death?

Did an operation precede death? yes Date of 11/28/27

Was there an autopsy? partial

What test confirmed diagnosis? Microscopic Section

(Signed) Warfield M. Firor, M. D.

, 19 (Address) John Hopk Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Roanoke Va — Date of Burial 2/6/27

20 UNDERTAKER: Joseph Ahrens — ADDRESS 221 Bway

very important. See instructions on back of

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 18714

101-001 E 18714

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital 8-45 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ruth Anna Duerr

(a) RESIDENCE NO. 2817 Erdman Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | white | single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXX

6 DATE OF BIRTH (month, day, and year) Dec 18/26

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | | 1 | 18 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work infant

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., ,Md.

PARENTS

10 NAME OF FATHER John F. Duerr

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore City Md,

12 MAIDEN NAME OF MOTHER Ethel D. Waters

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Somerset Co., Md.

14 Informant John F. Ruerr

(Address) 2817 Erdman Ave

15 Filed FEB - 6 1927 For C. BAILEY JONES, M. D. Registrar

very important. See instructions on back of

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 Feb 5/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. Waters, M. D.

(Coroner)

2/5/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Date of Burial Feb 8 1927

20 UNDERTAKER W. H. Ewh ADDRESS 532 E. Lanvale

Spec.—12-9-25—A Co.—200 Bks.

E 18715 HEALTH DEPARTMENT—CITY OF BALTIMORE 100-001 E 18715

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. _____ St., 4-25 Ward) REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Glanesky

(a) RESIDENCE NO. 1114 N. Greene St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth L Glanesky

6 DATE OF BIRTH (month, day, and year) June 3 1845

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| 81 | 82 | 8 | 1 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Germany

PARENTS

10 NAME OF FATHER George Glanesky

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Germany

12 MAIDEN NAME OF MOTHER Charlotte —

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Germany

14 Informant _____

(Address) Records

15 Filed FEB - 6 1927 19 _____ Registrar

very important. See instructions on back of

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 4 1927

17

I HEREBY CERTIFY, That I attended deceased from November 5, 1926, to February 4, 1927, that I last saw h.m. alive on February 4, 1927, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death? _____

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis? General & Laboratory

(Signed) O R Cooper Linell, M. D.

Feb 5 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Presbyterian, Govans Date of Burial Feb 7 1927

20 UNDERTAKER Cook ADDRESS 502 E North Ave

pec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18716

## CERTIFICATE OF DEATH.

E 18716

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST. WARD) 21-24

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Gunther

(a) RESIDENCE NO. 1140 Hanlicoke St WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Catherine Gunther

6 DATE OF BIRTH (month, day, and year) July 23, 1887

| 7 AGE Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|
| 39 | 6 | 12 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

086

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John W Gunther

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Catherine Gunther (Address) 1140 Hanlicoke St

15 Filed FEB - 6 1927 HARTSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 18, 1927, to Feb 5, 1927, that I last saw him alive on Feb 5, 1927, and that death occurred, on the date stated above, at 9 40 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolus following Operation for Appendicitis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes No Date of Jan 19/1927

Was there an autopsy?

What test confirmed diagnosis? clinical

(Signed) Clement K. Thorne, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western — DATE OF BURIAL Feb 8 1927

20 UNDERTAKER W. H. Cook — ADDRESS 807 E Monument

Cor.—12-9-25—A Co.—200 Bks.

E 18717

# HEALTH DEPARTMENT—CITY OF BALTIMORE

66 E 18717

## CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 906 E Pratt St., 35 Ward)

2-FULL NAME Isaac D. Spangler

(a) RESIDENCE NO. 906 E Pratt St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Anna

6 DATE OF BIRTH (month, day, and year): Aug 25 - 1858

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 68 | 5 | 5 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Day Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): O'H

(c) Name of employer: City

9 BIRTHPLACE (city or town): Balto

(State or country): Md

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town):

(State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): unknown

14 Informant: Mary Ann Spangler

(Address): 900 Bernard St

15 Filed FEB - 6 1926 19 C. Howard Jones K. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 3 - 1926

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Alcoholism

(Duration) yrs. 6 mos. 7 ds.

CONTRIBUTORY (Secondary) Chronic

(Duration) yrs. 1 ds.

Feb 5 1926 (Signed) G. C. Yates M. D.

(Coroner)

(Address) 1432 N Bray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore City Date of Burial 2/6 1926

20 UNDERTAKER: Wm Cook ADDRESS 502 E 11th St

very important. See instructions on back of

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18718

## CERTIFICATE OF DEATH.

29 E 18718

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 607 E 37th ST., 9-47 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Carrie

(a) RESIDENCE NO. 607 E 37th ST., WARD New York.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 20 1858

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 68 | 10 | 21 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron Worker

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 15 Years

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10 NAME OF FATHER David Carrie

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Ann Riccard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Elizabeth V Carrie
(Address) 607 E 37th St

15 Filed ..... 19 ..... Registrar

By .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/5/27 19

17 I HEREBY CERTIFY, That I attended deceased from Jan 18, 1927, to Feb 5, 1927.

that I last saw him alive on Feb 5, 1927.

and that death occurred, on the date stated above, at 5 20 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
Chronic Myocarditis
(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY
(Secondary)
(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? N.Y. City

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) John A. Fahey, M. D.

2/5/27 (Address) 8522 Germantown Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Michaels Cemetery New York City

DATE OF BURIAL Feb 8 1927

ADDRESS

20 UNDERTAKER Wm Cook 602 E 6th

Spec.—1-10-21—M&T—1500 Bks.

18719

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 18719

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 604 N. Broadway ST., 7 13 WARD)

2-FULL NAME Mary E. Armiger

(a) RESIDENCE NO. 604 N. Broadway ST., 7 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 10. 1859

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs or min. |
|---|---|---|---|---|
| | 67 | 7 | 24 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ct. Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Armiger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Armiger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Sallie Joselyn

(Address) 604 N. Broadway

15 Filed FEB-6 1927 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/7/27 19

17 I HEREBY CERTIFY, That I attended deceased from 8/1/26, 19 26, to Feb 7 19 27,

that I last saw h.. alive on Feb 7 19 27,

and that death occurred, on the date stated above, at 12 05 m.

The CAUSE OF DEATH* was as follows:

Heart Disease

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

2/8, 19 27 (Address) 704 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Feb 7 19 27

20 UNDERTAKER William G. Schaeffer

ADDRESS 1816 Mont

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18720

## CERTIFICATE OF DEATH.

126

E 18720

REGISTERED NO.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St., 76-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia Bratkowski

(a) RESIDENCE NO. 407 S. Bouldin St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 64 5-

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 82 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) —

(State or country) Prussia

PARENTS

10 NAME OF FATHER — ?

11 BIRTHPLACE OF FATHER (city or town) ?

(State or country) Prussia

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (City or town)

(State or country) Prussia

14 Informant (Address) [redacted] ORE CITY HOSPITALS

Filed FEB 6 1927 [redacted] Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 4 1927

17 I HEREBY CERTIFY, That I attended deceased from August 20 1925, to February 4, 1927, that I last saw h.. alive on February 3, 1927, and that death occurred, on the date stated above, at 7^10 A m.

The CAUSE OF DEATH* was as follows:

Arterial Sclerosis

Chronic Myocarditis, Incomplete

Peritonitis unknown etiology.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Tissue & laboratory

(Signed) R. Adolph Lull, M. D.

(Address) [redacted] BALTIMORE CITY HOSPITALS

*State the Disease causing death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schwartz Cemetery — Date of Burial Feby 7 1927

20 UNDERTAKER John Ulrich — ADDRESS 2008 Orleans

Very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

18721

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18721

## CERTIFICATE OF DEATH.

57

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE! (No. 900 Rutland Ave ST., 7-13 WARD)

2-FULL NAME John Faelker

1a) RESIDENCE NO. 900 Rutland Ave ST., WARD

(Usual place of abode) (If non resident give city or town and State)

Length of residence in city or town where death occurred 03 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~~[illegible]~~ married

6 DATE OF BIRTH (month, day, and year) Sept 8 - 1854

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 72 | 4 | 26 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Don Faelker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Don Faelker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Deanna Faelker (Address) 900 Rutland Ave

15 Filed B-6 1927 [illegible] Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1927

17

I HEREBY CERTIFY, That I attended deceased from June 30 1927, to July 7 1927,

that I last saw him alive on July 3 1927,

and that death occurred, on the date stated above, at 2:45 a.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) L. M. C. Parker, M. D.

July 10, 1927 (Address) 111 W Hoffman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL July 7 1927

20 UNDERTAKER John Ellerick

ADDRESS 2108 Orleans

Spec. 6-9-19 H. P. Co. 1000 Blks.

E 18724

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 18722

REGISTERED NO. 57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1905 Mc Elderry ST. 7-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna C. Keller

(a) RESIDENCE. No. 1905 Mc Elderry ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of David Keller

6 DATE OF BIRTH (month, day, and year) June 23 1866

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 60 | 7 | 12 | 11 |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER George Schmuck

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Dorit-knun

13 BIRTHPLACE OF MOTHER (city or town) " "
(State or country)

14 Informant Caspar Keller
(Address) 1905 Mc Elderry St.

15 Filed DEC 6 1927 H. JONES [illegible] Registrar

B - 6 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 31 1927, to Dec 4 1927.

That I last saw h[illegible] alive on Dec 3d 1927.

and that death occurred, on the date stated above, at 10.05 a m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia
(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Diabetis Pancreatis (right side)
(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Howard C Silver, M. D.

, 19 (Address) 3706 Liberty Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Dec 7 1927

20 UNDERTAKER John Leerich

ADDRESS 208 Orleans St

Spec.—12-9-25—A Co.—200 Blks.

E 18723

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

100-001

**E 18723**

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 7-4 Ward)

2-FULL NAME Harvey Parry

(a) RESIDENCE NO. 1604 Jefferson St. City Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | Colored | Singer |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1892

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 35 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 40

(c) Name of employer

9 BIRTHPLACE (city or town) Va

(State or country)

PARENTS

10 NAME OF FATHER James Parry

11 BIRTHPLACE OF FATHER (city or town) Va

(State or country)

12 MAIDEN NAME OF MOTHER Eliz Jones

13 BIRTHPLACE OF MOTHER (city or town) Va

(State or country)

14 Informant Friends

(Address) JOHNS HOPKINS HOSPITAL

Filed FEB 7 1927 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan 26 1927, to Jan 30, 1927, that I last saw h-- alive on Jan 30, 1927, and that death occurred, on the date stated above, at 10 50 a.m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

Streptococcus viridans septicaemia

(duration) yrs. mos. 15 ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) Milton Sherry, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D. C. Date of Burial Feb 7 1927

20 UNDERTAKER Undertaking Co. N. Dennis per. T. Ellison. ADDRESS 1303 Druid Hill Ave

Released from Hospital Feb 7

very important. See instructions on

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18724 CERTIFICATE OF DEATH E 18724

1-PLACE OF DEATH: Shot self in Franklin Square opposite Franklin Sq. Hospital

City of BALTIMORE: (No.) Pronounced dead at Franklin Square Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Vincent Londonesky

(a) RESIDENCE NO. 630 So. Monroe St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widower |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 16 1867

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 59 | 7 | 18 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) 450

(c) Name of employer —

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Clarence W. Henning

(Address) 630 So. Monroe St

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

3-7 1927 K.C.

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3rd 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, or Autopsy or Inquiry.) thereon and from the evidence obtained by Inquiry (Inquest, or Autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage Brain

Suicide — Shot self in head

(duration) at once

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Thos. B. Horton M. D.

(Coroner)

Feb 5 1927 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pine Grove Louden Cemetary Date of Burial Feb 7 1927

20 UNDERTAKER Chas B Kuchaudas ADDRESS 637 S Arcadia

very important. See instructions on back of

Spec.—12-9-25—A Co.—200 Bks.

Kelly

# HEALTH DEPARTMENT—CITY OF BALTIMORE

50

E 18725

E 18725

REGISTERED NO.

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 76-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leo Kelby

(a) RESIDENCE NO. 1105 S. Clinton St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | White | Single |

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 28 1914

| 7 AGE Years | Months | Days | IF LESS than 1 day....hrs. or....min. |
|---|---|---|---|
| 12 yrs. | 8 | 8 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER Philip Kelby

11 BIRTHPLACE OF FATHER (City or town) Mich.

(State or country) (Deceased)

12 MAIDEN NAME OF MOTHER Mary Murphy

13 BIRTHPLACE OF MOTHER (City or town)

(State or country) Canada (Deceased)

14 Informant Records

(Address)

15 Filed 19 H. A. Rossiter, M. D. Registrar

71927

Per R.M.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 6 19 27

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 19 27, to Feb. 6, 19 27, that I last saw h. alive on Feb. 6, 19 27, and that death occurred, on the date stated above, at 5 60 A.m.

The CAUSE OF DEATH* was as follows: Fibro myxoma of thoracic vertebrae

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? 1105 S. Clinton St.

Did an operation precede death? yes Date of 5 Feb '27.

Was there an autopsy? No

What test confirmed diagnosis? study of portion of tumor.

(Signed) H. E. Handley, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's Cemetery Date of Burial Feb 8 1927

20 UNDERTAKER A. S. Marshall ADDRESS 3539 Falls Road

very important. See instructions on back

Cor.—1-12-23—M&T—100 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18726

## CERTIFICATE OF DEATH.

90 E 18726

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2625 Bernard ST., 12-51 (WARD)

2-FULL NAME Laura Sinclair

(a) RESIDENCE NO. 2625 Bernard ST., 12 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| F. | W | Widow |

If married, widowed, or divorced HUSBAND of (or) WIFE of Frances P Sinclair

DATE OF BIRTH (month, day, and year) May 12-1858

| AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 68 | 8 | 23 | |

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) 0
(c) Name of employer

BIRTHPLACE (city or town) Md
(State or country)

10 NAME OF FATHER Joseph Bowers

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

Informant Mrs. M. Jarnagin
(Address)

Filed FEB 7 1927, 192 ..... Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/5 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (Education) yrs. mos. ds.

(Signed) Jno F Mowbray, M. D.
(Coroner.)

2/6, 192 7 (Address) 2632 Roland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ..... mos., ..... ds. In the State ..... yrs., ..... mos., ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Feb 8 1927

20 UNDERTAKER J M Cook — ADDRESS 502 E Monument

Spec.—12-9-25—A Co.—200 Bks.

1926 E 18727

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

X 44 1

E 18727 REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 720-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Austin

(a) RESIDENCE NO. 1925 W. Franklin St. City Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | widower |

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Josephine

6 DATE OF BIRTH (month, day, and year) unknown.

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 77 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) West Va.

(State or country)

PARENTS

10 NAME OF FATHER Thomas Austin

11 BIRTHPLACE OF FATHER (city or town) Unk.

(State or country) U.S.

12 MAIDEN NAME OF MOTHER Leonia Lanchaster

13 BIRTHPLACE OF MOTHER (city or town) Unk.

(State or country) U.S.

14 Informant Records - JOHNS HOPKINS HOSPITAL

(Address)

15 Filed FEB - 7 1927 H. WILSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan 15 1927, to Feb 6, 1927, that I last saw him alive on Feb 6, 1927, and that death occurred, on the date stated above, at 2.55 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(duration) yrs. 7 mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes. Date of 1/29/27.

Was there an autopsy? Yes.

What test confirmed diagnosis? X-ray - Specimen

(Signed) John Hopkins, M. D.

, 19 (Address) John Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Martinsburg. W. Va. Date of Burial 2/8 1927

20 UNDERTAKER Wm Cook. ADDRESS 502 E York

very important. See instructions on back of

pec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

101-001

E 18728

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
18728
CITY OF BALTIMORE: (No. 1132 Harford ave. 10-14 WARD)

2-FULL NAME Margaret. Keys.

(a) RESIDENCE NO. 1132 Harford ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married,~~ ~~or Divorced~~, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Late Samuel Keys

6 DATE OF BIRTH (month, day, and year): March 17. 1853

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 73 | 10 | 11 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Georgia New York.

PARENTS

10 NAME OF FATHER: Abraham Tilson

11 BIRTHPLACE OF FATHER (city or town) (State or country): New York.

12 MAIDEN NAME OF MOTHER: ~~Ida Wheelhouse~~

13 BIRTHPLACE OF MOTHER (city or town) (State or country): New York.

14 Informant: Ida. Keating

(Address): 1132. Harford ave.

FEB 7 1927 H. [illegible] Registrar.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/4 1927

17 I HEREBY CERTIFY, That I attended deceased from 2/4, 1927, to 2/4, 1927, that I last saw her alive on 2/4, 1927, and that death occurred, on the date stated above, at 11.15 P.M.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) ... yrs. mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D. Blumenthal, M. D.

2/5, 1927 (Address) 914 E. Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Cem Hampden

DATE OF BURIAL: 2/7 1927

20 UNDERTAKER: George J Ruth

ADDRESS: 1725 Harford Ave

pec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18729

## CERTIFICATE OF DEATH.

131 E 18729

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1718 N. Carolina ST. 9-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Dorothy Hyson

(a) RESIDENCE NO. 1718 N. Carolina ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 8 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | white | Single |

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 9-1925

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs or ... min. |
|---|---|---|---|---|
| | 1 | 8 | 25 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Raymond S. Hyson

11 BIRTHPLACE OF FATHER (city or town) Hampstead (State or country)

12 MAIDEN NAME OF MOTHER Mary D. Collins

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Mr. Hyson (Address) 1718 N. Carolina

15 Filed FEB 7 1927 19 C. HARRISON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 4 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb 1 1927, to Feb 4 1927,

that I last saw her alive on Feb 4 1927

and that death occurred, on the date stated above, at 6 30 P m

The CAUSE OF DEATH* was as follows:

Pyelitis Acute

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Convulsion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Randallstown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Laboratory

(Signed) C. Leiningood Lind, M. D.

2-5, 1927 (Address) 101 St Paul

* State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge — DATE OF BURIAL Feb 7 1927

UNDERTAKER D. Frew McCully — ADDRESS 130 E. Fort

Spec.—1-10-21—M&T—1500 Bks.

18730

# HEALTH DEPARTMENT—CITY OF BALTIMORE

62 E 18730

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 58 Mason St. ST. 25-78 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herbert William Warfield

(a) RESIDENCE No. 58 Mason St. Masonville WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 21-192[illegible]

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | | | 13 1X | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Masonville, Baltimore md

PARENTS

10 NAME OF FATHER George Warfield

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore md

12 MAIDEN NAME OF MOTHER Lizzie Carroll

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore md

14 Informant George Warfield
(Address) Masonville md

15 Filed ... 19... C. HAMPTON JONES, M. D. Registrar

B-7 1927 P. KK

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 21 .1927. to Feb 4 .1927.

that I last saw h[illegible] alive on Feb 4 .1927.

and that death occurred, on the date stated above, at 7 p. m.

The CAUSE OF DEATH* was as follows:

Sudden Cardiac Failure possibly due to Hypertension -

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Leon J. Hyman, M. D.

Feb. 6 1927 (Address) Curtis Bay md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery DATE OF BURIAL Feb. 7 1927

20 UNDERTAKER George L. Schwabe ADDRESS 1101 Fulk Ave

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18731

## CERTIFICATE OF DEATH.

129 E 18731.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 433 Ludlow ST. 23-31 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Archie B Hackett

(a) RESIDENCE NO. 426 Leadenhall ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ada. Hackett

6 DATE OF BIRTH (month, day, and year) March 23-1878

| 7 AGE Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|
| 28 | 10 | 11 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boat Black

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N C

PARENTS

10 NAME OF FATHER Oscar Hackett

11 BIRTHPLACE OF FATHER (city or town) (State or country) N C

12 MAIDEN NAME OF MOTHER Alice Bray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N C

14 Informant Ada Hackett
(Address) 426 Leadenhall St

15 Filed ..... 19 ..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/3 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 12, 1926 to July 3 1927

that I last saw h[illegible]ive on 2/2 1927

and that death occurred, on the date stated above, at 7 02 m.

The CAUSE OF DEATH* was as follows: Chronic Nephritis

(duration) — yrs. 9 mos — ds.

CONTRIBUTORY (Secondary) Blood Pressure & Loss of Vision

(duration) — yrs. 2 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

, 19 (Address) 345 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gastonia N. C. DATE OF BURIAL Feb 7 1927

20 UNDERTAKER J D Brown & Son ADDRESS 108 W. Mount

FEB 7 1927

V3 all O R R to Washington N C

Spec.—12-9-25—A Co.—200 Bks.

E 18732

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18732

## CERTIFICATE OF DEATH.

90

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2543 Edmondson Ave. 20-69 Ward)

2-FULL NAME David Harman Cross

(a) RESIDENCE NO. 2543 Edmondson Ave. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | married. |

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Ella E. Cross.

6 DATE OF BIRTH (month, day, and year) August 3- 1874.

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 52 | 6. | 2. | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Linotype Operator.

(b) General nature of industry, business, or establishment in which employed (or employer) Printing 63

(c) Name of employer Balto Sun.

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER John Cross

11 BIRTHPLACE OF FATHER (city or town) Balto,

(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Weddigen

13 BIRTHPLACE OF MOTHER (city or town) Balto,

(State or country) Md.

14 Informant Ellen E. Cross

(Address) 2543 Edmondson ave.

15 Filed FEB 7 1927 Registrar

very important. See instructions on back.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February-5-1927. 19

17 I HEREBY CERTIFY, That I attended deceased from October 25 1926, to February 5- 1927, that I last saw him alive on February 3- 1927, and that death occurred, on the date stated above, at 12:25 A. m.

The CAUSE OF DEATH* was as follows:

organic heart disease

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Arthritis Deformans

(duration) 5 yrs. 2 mos. — ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? physical signs

(Signed) Chester Roland, M. D.

2-5-1927 (Address) 2532 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem Date of Burial Feb 8 1927

20 UNDERTAKER H. J. Tuckerman Jr. ADDRESS N. Pa. Ave

pec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18733

E 18733

## CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2123 Callowhill ST. 13-59 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Landy

(a) RESIDENCE NO. 2123 Callowhill ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? 17 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Landy

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 52 — Months: — — Days: — — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Zack Landy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Joseph Landy

(Address): 2123 Callowhill ST.

FEB - 7 1927

Filed ... 19 ... HARRY JONES, R.

Per ... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/7 19 27

17

I HEREBY CERTIFY, That I attended deceased from Feb 1, 19 27, to Feb 7, 19 27

that I last saw h[illegible] alive on Feb 7, 19 27

and that death occurred, on the date stated above, at 12 m

The CAUSE OF DEATH* was as follows:

Chron Endocarditis & Myocarditis

(duration) 2 yrs. mos da.

CONTRIBUTORY (Secondary) Pulmonary edema

(duration) yrs. mos. 2 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Clinical

(Signed) W. F. Baldwin, M. D.

2/7, 1927 (Address) 820 Arlington

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale

DATE OF BURIAL: 2/9 19 27

UNDERTAKER: Jack Levin

ADDRESS: 439 E. Baltimore

ec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18734

## CERTIFICATE OF DEATH.

E 18734

74-001

1-PLACE OF DEATH

REGISTERED NO. 27-48

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 5505 Govane Ave St., WARD

2-FULL NAME Daniel Duigley

(a) RESIDENCE NO. 5505 Govane Ave St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~. (write the word): Married

5a If married, ~~widowed~~, or ~~divorced~~ HUSBAND of ~~(or) WIFE of~~ Anne Lynch Duigley

6 DATE OF BIRTH (month, day, and year) August 5 1862

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 65 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: T. Duigley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Tracy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Miss D. Duigley

(Address) 5505 Govane Ave

15 Filed ... 19...

16 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6 * 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 23, 1927, to Feb-6, 1927, that I last saw h[e] alive on Feb-6, 1927, and that death occurred, on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) H. C. Koen, M. D.

2-6-1927 (Address) 5600 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem

DATE OF BURIAL: Feb 9 1927

20 UNDERTAKER: Henry J. Jenkins's Sons Co

ADDRESS: Orchard & Gorsuch

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

18735 90 E 18735

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH West Baltimore General Hospital

CITY OF BALTIMORE: (No.) Raynor and Dukeland ST., 16-67 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Russell Farrar

(a) RESIDENCE NO. 3104 Belmont ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word) Married

6a If married, widowed, or divorced HUSBAND of ~~or) WIFE of~~ Alassia L. Farrar

6 DATE OF BIRTH (month, day, and year) Feb. 10, 1895

7 AGE

| Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|
| 31 | 11 | 26 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) Insurance

(c) Name of employer Ocean Accid. & Guar. Corp.

9 BIRTHPLACE (city or town) (State or country) Washington D. C.

PARENTS

10 NAME OF FATHER Richard D. Farrar

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hyde Co. N. C.

12 MAIDEN NAME OF MOTHER Gertrude Sulcher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dracoke N. C.

14 Informant (Address) Mrs. Alassia L. Farrar 3104 Belmont St.

15 Filed FEB - 7 1927 Registrar HAMPSON JONES, M. D.

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/6 1927

17 I HEREBY CERTIFY, That I attended deceased from 2/1, 1927 to 2/6, 1927 that I last saw h alive on 2/6, 1927 and that death occurred, on the date stated above, at 6:40 P m.

The CAUSE OF DEATH* was as follows:

Aortic regurgitation

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Clinical findings

(Signed) Benjamin Miller, M. D.

, 19 (Address) W. B. G. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Littleton N. C. DATE OF BURIAL Feb 8 1927

20 UNDERTAKER Robert L. Tillett ADDRESS Edenton

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18736

## CERTIFICATE OF DEATH.

129 E 18736

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. _____ St., 6-4 Ward)

2-FULL NAME Connie Grant

(a) RESIDENCE NO. 1522 E. Fayette St. Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Negro | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1893

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 34 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) 69

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) South Carolina

PARENTS

10 NAME OF FATHER Robert Gray

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Georgia

12 MAIDEN NAME OF MOTHER Louise Brown

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Mass

14 Informant _____

(Address) Records

FEB 7 1927

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 5 1927

17 I HEREBY CERTIFY, That I attended deceased from December 27, 1926, to February 4, 1927, that I last saw h__ alive on February 4, 1927, and that death occurred, on the date stated above, at 8:20 P. m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency

Myocardial Hypertrophy

Chronic Nephritis (Interstitial)

(duration) ? yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) ____ yrs. ____ mos. 3 ds.

18 Where was disease contracted

If not at place of death? _____

Did an operation precede death? no Date of _____

Was there an autopsy? yes

What test confirmed diagnosis? general & laboratory

(Signed) E. E. Cooper Lintl, M. D.

Feb 5, 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Woodlawn cemetery Feb 9 1927

UNDERTAKER ADDRESS

Edward Rayson Records 1631

Spec.—12-9-25—A Co.—200 Bks

E 18737

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 18737

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) 805 Pierce St. 18-26 (Ward)

2-FULL NAME Bailey Addison

(a) RESIDENCE NO. 805 Pierce St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col'd

5 Single, Married, Widowed, or Divorced, (write the word): Mar.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Susan Addison

6 DATE OF BIRTH (month, day, and year): Jan 1864

7 AGE: Years 61 | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stoker

(b) General nature of industry, business, or establishment in which employed (or employer): Marine

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Va.

PARENTS

10 NAME OF FATHER unk

11 BIRTHPLACE OF FATHER (city or town)

(State or country) unk

12 MAIDEN NAME OF MOTHER unk

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) unk

14 Informant: Alfred Addison

(Address) 1406 Hanover

15 Filed ..... 19 ..... Registrar

FEB 7 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Feb 3 19 27

17 I HEREBY CERTIFY, That I attended deceased from Dec 9 19 26, to Feb 3, 19 27, that I last saw h..... alive on Feb 3, 19 27, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 25 ds.

CONTRIBUTORY (Secondary) Organic Dis. of Heart

(duration) Yrs. 1 mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Howard, M. D.

2/4/27 (Address) 1406 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary — Date of Burial: Feb 7 19 27

20 UNDERTAKER: John H. Toadvine — ADDRESS 1027 Edmondson Ave

very important. See instructions on

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18738

E 18738

## CERTIFICATE OF DEATH

38

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 220 Eutaw Street S., 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs D Henson

(a) RESIDENCE NO. 220 Eutaw St-Mt Vernon S. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Georgiana Henson

6 DATE OF BIRTH (month, day, and year): 1854

7 AGE: Years 73 Months — Days — IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Stevedore Co

(c) Name of employer: General

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Perry Henson

11 BIRTHPLACE OF FATHER (City or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Charlotte Roy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Carrie Blackwell

(Address) 220 Eutaw St. Mt Vernon

15 Filed ..... 19 ..... Registrar .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/31 19 27

17 I HEREBY CERTIFY, That I attended deceased from 1/11 19 27, to 1/31 19 27

that I last saw h... alive on 1/31 19 27

and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial (Syphilitic) Nephritis

(duration) 1 yr 3 mos ... ds.

18 Where was disease contracted if not at place of death? Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) ..... M. D.

1/31 19 27 (Address) 908 Sharp St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — Date of Burial 2-7 19 27

20 UNDERTAKER: John H Jordan — ADDRESS 112

FEB 7 1927 C. HERMON JONES Registrar

very important. See instructions on back of certificate

ec.—1-12-23—M&T—500 Bks.

E 18739 HEALTH DEPARTMENT—CITY OF BALTIMORE E 18739

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH Bon Secours Hospital ST., 28-6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

2-FULL NAME Mrs. Mary Monaghan

(a) RESIDENCE NO. Swan ave & Roberts Rd. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): widow

6a If married, widowed, or divorced HUSBAND of or) WIFE of widow of the late Michael Monaghan

6 DATE OF BIRTH (month, day, and year) Unknown 1848

7 AGE: Years 78; Months —; Days —; If LESS than 1 day, ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John McCormick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mr. A. J. Monaghan

(Address) Swan ave & Roberts Rd

15 Filed 7 1927 C. HARTMAN JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 25, 1927, to Feb. 6, 1927, that I last saw her alive on Feb. 6, 1927, and that death occurred, on the date stated above, at 11.30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Acidosis

Senility

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Geo. D. Lipsey, M. D.

, 19 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL Feby 9 1927

20 UNDERTAKER Mrs E. J. Logue & Son

ADDRESS 901 Hollins

Spec.—1-10-21—M&T—1500 Bks.

E 18740

# HEALTH DEPARTMENT—CITY OF BALTIMORE

129 E 18740

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 643 N Enson St 5-8 WARD)

2-FULL NAME Herbert G. Emery.

(a) RESIDENCE NO. 643 N. Enson ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): April 14th 1884

7 AGE — Years: 42 — Months: 9 — Days: 18 — If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Rigger

(b) General nature of industry, business, or establishment in which employed (or employer): ...

(c) Name of employer: ...

9 BIRTHPLACE (city or town) (State or country): Balto City

PARENTS

10 NAME OF FATHER: Arthur Emery

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maine

12 MAIDEN NAME OF MOTHER: Jennie Stitch

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto.

14 Informant (Address): Jennie Emory 643 N Enson St

15 Filed ... 19 ... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/4. 1927.

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1926, to Feb. 4 1927.

that I last saw h[e] alive on Feb. 3rd 1927, and that death occurred, on the date stated above, at 8:50 a. m.

The CAUSE OF DEATH* was as follows:

Hert Dilatation Heart

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Chronic Nephritis Uremia

(duration) 3 yrs. 3 mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) C. N. Reynolds Jr. M. D.

2/4, 1927 (Address) 1520 E. 3 Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem — DATE OF BURIAL: Feb 7 1927

20 UNDERTAKER: Geo M. Frink & Son — ADDRESS: 811 N Carey

Spec.—1-10-21—M&T—1500 Bks.

E 18741 HEALTH DEPARTMENT—CITY OF BALTIMORE E 18741

## CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 50 E. Echodale ave ST. Hamilton 27-44 Wards)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Freda M. Everett

(a) RESIDENCE NO. 50 E. Echodale ave. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis R. Everett

6 DATE OF BIRTH (month, day, and year) Dec. 1st 1909

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 17 | 2 | 5 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) Forest Park

(State or country) Illinois

PARENTS

10 NAME OF FATHER Joseph Urbanyer

11 BIRTHPLACE OF FATHER (city or town) Alban

(State or country) Austria

12 MAIDEN NAME OF MOTHER Theresa Ander

13 BIRTHPLACE OF MOTHER (city or town) Alban

(State or country) Austria

14 Informant Louis R. Everett

(Address) 50 E. Echodale Ave. Hamilton

15 Filed FEB 7 1927 C. HARRY JONES, R.

By Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 24 1926 to Feb 6 1927.

that I last saw h alive on Feb 6 1927.

and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas Smuck M. D.

2/6 1927 (Address) 4706 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Parkwood Cemetery | Feb. 8 1927 |
| 20 UNDERTAKER | ADDRESS |
| Frederick Lassahn & Son | Fullerton |

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

18742

E 18742

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Normandie Apts. St. Paul & 27th Sts. Ward) 12-50

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert D Craig

(a) RESIDENCE NO. St Paul & 27th St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine V Craig

6 DATE OF BIRTH (month, day, and year) Dec 21, 1869.

| 7 AGE | Years | Months | Days | IF LESS than 1 day ...hrs. or ...min.. |
|---|---|---|---|---|
| | 57 | 1 | 14 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 166

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer John E Hurst Co

9 BIRTHPLACE (city or town) Balto

(State or country) Md

PARENTS

10 NAME OF FATHER John M Craig

11 BIRTHPLACE OF FATHER (City or town) Balto

(State or country) Md

12 MAIDEN NAME OF MOTHER Matthews Lewis

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md

14 Informant Katherine V Craig

(Address) Normandie Apts

Filed FEB - 7 1927

C. Hampton Jones Jr. Registrar

By RR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5 1927

17 I HEREBY CERTIFY, That I attended deceased from October, 1921, to February 5, 1927, that I last saw h in alive on February 4, 1927, and that death occurred, on the data stated above, at 4.45 A m.

The CAUSE OF DEATH* was as follows: Cardio vascular hypertension

(duration) 5 yrs. mos. da.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(duration) yrs. mos. 4 da.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Clinical Exam

What test confirmed diagnosis?

(Signed) Frank M Little M. D.

2/6, 1927 (Address) 2435 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ft Holmes, Ellicott City Date of Burial Feb 5 1927

20 UNDERTAKER W. M. Cook

ADDRESS 508 E Fayette

very important. See instructions on back of

Cor.—12-9-25—A Co.—200 Bks.

E 18743

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 18743

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 4205 Maine Ave. 16-67 Ward)

2-FULL NAME Henry P. Chambers.

(a) RESIDENCE NO. 290 E Cumberland St. Ward _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | Widower |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kate P. Chambers

6 DATE OF BIRTH (month, day, and year) Aug. 11, 1851

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 75 | 5 | 24 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Decorator retired
(b) General nature of industry, business, or establishment in which employed (or employer) 63
(c) Name of employer

9 BIRTHPLACE (city or town) _____
(State or country) Balto. Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) _____
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country) Unknown

14 Informant James H. Chambers
(Address) 4205 Maine Ave

15 Filed B-7 1927 19 [illegible] Registrar

very important. See instructions on reverse side.

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Feb 5. 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) .....yrs. 6 mos. .....ds.

CONTRIBUTORY (Secondary) see history

(duration) .....yrs. .....mos. .....ds.

(Signed) J. J. Hennessy M. D.
(Coroner)

1927 (Address) 2 E Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — Date of Burial 2/7 1927

20 UNDERTAKER Wm. Cook — ADDRESS 502 E North Ave

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18744

## CERTIFICATE OF DEATH.

129 E 18744

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1126 Leadenhall ST., 23-31 WARD)

2-FULL NAME Jane A. McCullough

(a) RESIDENCE NO. 1126 Leadenhall ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jethro T. McCullough

6 DATE OF BIRTH (month, day, and year): April, 2nd 1840

7 AGE: Years 87; Months 10; Days 4; If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Chester Co. Pa.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Dr. G. S. Sill 1126 Leadenhall St.

15 Filed FEB - 7 1927

C. HARTMAN JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 6th. 1927

17 I HEREBY CERTIFY, That I attended deceased from October, 1926 to 2-5-27, 1927, that I last saw her alive on 2-5-27, 1927, and that death occurred, on the date stated above, at 11.40 A m.

The CAUSE OF DEATH* was as follows:

Anaemia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (secondary): Cardio-Vascular Renal Disease ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) H. V. Harper M. D.

2/7, 1927 (Address) 817 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Nottingham Md

DATE OF BURIAL: Feb 8" 1927

20 UNDERTAKER: Joseph B Cook

ADDRESS: 1003 N. Gilmor St

Spec.—5-19-13—M. & T.—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18745

## CERTIFICATE OF DEATH.

E 18745

1-PLACE OF DEATH

REGISTERED NO. C 27-54

CITY OF BALTIMORE: (No. 2 Oakley Ave. St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Susan Elizabeth Lopez

(Residence in Baltimore: No. 2 Oakley Ave Bacc. St.; yrs. 5 mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, ~~MARRIED~~, WIDOWED, ~~OR DIVORCED~~. (Write the word.) Widow

6-DATE OF BIRTH. Sept 9, 1839. (Month) (Day) (Year)

7-AGE. 77 yrs. 6 mos. 25 ds. If LESS than 1 day, ....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Anne Arundel Co Md

PARENTS.

10-NAME OF FATHER. Owen M Waters

11-BIRTHPLACE OF FATHER (State or Country). England

12-MAIDEN NAME OF MOTHER Susan R Moran.

13-BIRTHPLACE OF MOTHER (State or Country). Anne Arundel Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Herbert M. Lopez

(Address) Oakley Rd. nr Washington

15- FEB 7 1927

C. HARRISON JONES, M.D. Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 6, 1927. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 5 1926. to Feb 6 1927.

that I saw her alive on Feb 6 1927.

and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis 2 days

Hypostatic Pneumonia

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(Duration) 2 yrs. mos. ds.

(Signed) H. D. Wood M.D. M. D.

Feb 7, 1927. (Address) 3516 Park Heights

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Loudon Park. DATE OF BURIAL. Feb. 8, 1927

20-UNDERTAKER Geo. P. Cook ADDRESS 1003 W. Baltimore St.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 18746 (1-PLACE OF DEATH)

21-002

E 18746 REGISTERED NO.

City of BALTIMORE: (No. University Hospital St. 4-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Summer Staples

(a) RESIDENCE NO. Md. Training School St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna G. Staples

6 DATE OF BIRTH (month, day, and year) December 20, 1885

| 7 AGE | Years | Months | Days | IF LESS than 1 day ... hrs. or ... min. |
|---|---|---|---|---|
| | 41 | 1 | 15 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cottage Master

(b) General nature of industry, business, or establishment in which employed (or employer) Md. Training School for Boys

(c) Name of employer

9 BIRTHPLACE (city or town) Watkins Glen

(State or country) New York

PARENTS

10 NAME OF FATHER Frank Charles Staples

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Vermont

12 MAIDEN NAME OF MOTHER Kate Gallagher

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Mrs. S. L. Staples

(Address) Md. Training School

15 Filed ..., 19... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 3, 1927, to Feb 4, 1927

that I last saw him alive on Feb 4, 1927

and that death occurred, on the date stated above, at 330 P m.

The CAUSE OF DEATH* was as follows:

Pneumococcic Cerebrospinal meningitis. Pneumococcic Septicemia

(duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Spinal Puncture & Blood Culture

(Signed) Charles Edwards, M. D.

Feb. 4, 1927 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Washington, D. C. | Feb. 8, 1927 |

20 UNDERTAKER Joseph J. Cook ADDRESS 1003 W. Balto St

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

18747

# HEALTH DEPARTMENT—CITY OF BALTIMORE

92 E 18747

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 703 Brook Avenue ST., Raspeburg WARD) 27-44

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles A. Dorsey

(a) RESIDENCE NO. Sudbrook Lane, Pikesville ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ~~[illegible]~~ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULAPS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth C. (Litsinger) Dorsey

6 DATE OF BIRTH (month, day, and year) January 1, 1876

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 51 | 1 | 3 4 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Construction Supt.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER William Dorsey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Harner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant William Dorsey

(Address) Anthony Dorsey, Jones, M. D.

15 Filed FEB 7 1927 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 4, 1927

17

I HEREBY CERTIFY, That I attended deceased from January 23, 1927 to February 4, 1927, that I last saw him alive on February 4, 1927, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Coronary Embolism.

(duration) yrs. mos 13 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. L. Wilkinson A. L. Wilkinson, M. D.

2/5, 1927 (Address) 13 N. Belair Rd. Raspeburg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery DATE OF BURIAL Feb 8 1927

20 UNDERTAKER J. F. Elmes & Son ADDRESS Reisterstown

Spec. 12-9-25—A Co.—200 Blks.

E 18748

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

74-00 E 18748

1-PLACE OF DEATH

REGISTERED NO._____

City of BALTIMORE: (No._____ St. 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Toppings

(a) RESIDENCE NO. 720 N. Bruce St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Negro | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1872

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 53 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) ?

14 Informant_____

(Address) Records

Filed FEB 7 1927 C. HAMPSON JONES, M. D., Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 5 1927

17 I HEREBY CERTIFY, That I attended deceased from August 20, 1925, to February 5, 1927, that I last saw h~~is~~ alive on February 5, 1927, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Hypertension

Arterial Sclerosis

Residual Hemiplegia

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) ____ yrs. ____ mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? N. C. Date of_____

Was there an autopsy?

What test confirmed diagnosis? general & laboratory

(Signed) E. Boteler Smith, M. D.

Feb 6 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cem Date of Burial Feb 1927

UNDERTAKER Daniel Easton ADDRESS 916 Bond ave

Very Important. See instructions.

BALTIMORE CITY HOSPITALS

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18749

## CERTIFICATE OF DEATH.

129 E 18749

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3608 Park Heights Ave (St.) 15-54 (WARD)

2-FULL NAME Henry F. Meusel

(a) RESIDENCE NO. 3608 Park Heights Avenue. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary E Meusel.

6 DATE OF BIRTH (month, day, and year): June 24 1859

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 67 | 7 | 10 11 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Daniel Meusel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Barbara Dickhaus

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Miss Naomi Meusel

(Address) 3608 Park Heights Ave

FEB 7 1927

C. PARSONS JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 4 1927

17 I HEREBY CERTIFY, That I attended deceased from June 3 1926 to Feb 4 1927.

that I last saw him alive on Feb 3 1927.

and that death occurred, on the date stated above, at 6:10 p m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage Apoplexy

(duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary) during Parenchymatous Nephritis arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of —

Was there an autopsy? no —

What test confirmed diagnosis? urinalysis; Symptoms

(Signed) Julia C. Loos, M. D.

2-4, 1927 (Address) 1713 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem

DATE OF BURIAL: 2-8 1927

20 UNDERTAKER: Mrs Chas A G Kohler

ADDRESS: N Arlington Ave

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18750

181-001

E 18750

## CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 442 N. Gay St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Allen Forbes

(a) RESIDENCE NO. 442 N. Gay St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs. Kate Forbes

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE: Years 63 Months Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): 015

(c) Name of employer

9 BIRTHPLACE (city or town): Iowa

(State or country)

PARENTS

10 NAME OF FATHER: Geo Forbes

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Mc Cumber

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Indiana

14 Informant: Mrs Kate Forbes

(Address): 442 N. Gay

15 Filed....., 19..... Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxiated by illuminating Gas accidental

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) M M Ruley M. D.

(Coroner)

Feb. 7, 19 27 (Address) 1032 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — Date of Burial: Feb. 9 1927

20 UNDERTAKER: Henry Storch Son — ADDRESS: 1201 E Eager St

very important. See instructions on back

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 18751 — 1-PLACE OF DEATH — REGISTERED NO. E 18751

City of BALTIMORE: (No. 1400 N. Washington St. 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John. J. Reberger

(a) RESIDENCE NO. 1400 N. Washington St. Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 78 yrs. — mos. — ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? — yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widower |

5a If married, widowed, or divorced
HUSBAND of the late
(or) WIFE of Louisa F. Reberger

6 DATE OF BIRTH (month, day, and year) Not stat

| 7 AGE | Years | Months | Days | IF LESS than 1 day ... hrs. or ... min.. |
|---|---|---|---|---|
| | 78 | — | — | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (City or town) Not Kn (State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Kn (State or country)

14 Informant Mrs M. L. Magunnis
(Address) 1400 N Washington St

15 Filed ..., 19... C. HARRISON JONES, M. D. Registrar
By ...

FEB - 7 1927

very important. See instructions on back of certificate.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 6 1927

17 I HEREBY CERTIFY, That I attended deceased from 1/7 ..., 1927 .. to 2/6 ..., 1927.
that I last saw him alive on 2/6 ..., 1927.
and that death occurred, on the date stated above, at 10 15 P. m.

The CAUSE OF DEATH* was as follows:
Natural Regurgitation

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Degeneration

(duration) ... yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis? Clinical symptoms

(Signed) Daniel Miller M. D.
2/6, 1927 (Address) 1500 Bdway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| New Cathedral Cemetery | Feb 9 1927 |
| 20 UNDERTAKER Henry Steed & Son | ADDRESS 301 E Eager St |

Spec.—12-9-25—A Co.—200 Bks.

18752

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 18752

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home & Infirmary

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. _____ St., 7-13 Ward)

2-FULL NAME Mr Henry P. Strit

(a) RESIDENCE NO. 1033 McDonough St. St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. ___ mos. ___ ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Elizabeth A. Strit.

6 DATE OF BIRTH (month, day, and year) June 11 1872

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 55 | — | 15 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stock Clerk for

(b) General nature of industry, business, or establishment in which employed (or employer) Westinghouse Co.

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md

(State or country)

PARENTS

10 NAME OF FATHER John A. Strit

11 BIRTHPLACE OF FATHER (city or town) Germany

(State or country)

12 MAIDEN NAME OF MOTHER Margaret Kellerman

13 BIRTHPLACE OF MOTHER (city or town) Germany

(State or country)

14 Informant Mrs. Elizabeth A. Strit

(Address) 1033 McDonough St

15 Filed FEB. 7 1927 HARRY S. JONES, M.D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6th 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb 5th 1927, to Feb 6 1927, that I last saw him alive on Feb 6 1927, and that death occurred, on the date stated above, at 11.25 P m.

The CAUSE OF DEATH* was as follows:

Empyema (Spirochaetal)

(duration) ___ yrs. ___ mos. 10 ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) ___ yrs. ___ mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Feb 5/26.

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

Feb 7 1927 (Signed) Vernon N. Norman, M. D. (Address) Church Home Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery Date of Burial Feb. 10 1927

20 UNDERTAKER Henry Stock Son ADDRESS 1901 E Eager St

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

71-001

E 18753

## CERTIFICATE OF DEATH.

E 18753

REGISTERED NO.

I-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 2637 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Beatrice Gentile

(a) RESIDENCE NO. 248 S. 5th St (Highlandtown) Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ) yrs. ) mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | white | single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of XXX

6 DATE OF BIRTH (month, day, and year) Jan 6th 1926

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 1 | 1 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Samuel Gentile

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimae

12 MAIDEN NAME OF MOTHER Thelma Waylan

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant Hopkins Hospital

(Address)

15 Filed 2/8 1927 C. HARRISON JONES, M. D.

Registrar

Per

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 Feb 6/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) and that said deceased came her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Meningitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) undetermined

(duration) yrs. mos. ds.

(Signed) J. C. Hall, M. D.
(Coroner)

2/7/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary — Date of Burial Feby 11 1927

20 UNDERTAKER Frank V. Piperone — ADDRESS 2815 E. Balto.

very important. See instructions on reverse side.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18754 — CERTIFICATE OF DEATH. — 179 — E 18754

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2203 Preston Place ST. 8-12 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara Jelinek

(a) RESIDENCE NO. 2203 Preston Place ST, WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? 40 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank Jelinek

6b DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 77 — Months: — Days: — If LESS than 1 day, hrs or min: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 034

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Austria

PARENTS

10 NAME OF FATHER: John Matula

11 BIRTHPLACE OF FATHER (city or town) (State or country): Austria

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Austria

14 Informant: Laurence Mumaugh

(Address) 2203 Preston Place

15 Filed ..... 1927 C. HAMPTON JONES, M. D. ....., 19 .....

By ..... Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 9, 1927, to Feb. 6, 1927,

that I last saw her alive on Feb. 6, 1927

and that death occurred, on the date stated above, at 11 30 A.m

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Vincent V. Joska, M. D.

, 19 (Address) 845 N. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westminster Grd — DATE OF BURIAL: Feb 9 1927

20 UNDERTAKER: Frank Evans Son — ADDRESS: 1906 Eastern

Spec.–7-17-26—A Co.—200 Bks.

E 18755

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

118-00 E 18755

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. 25-77 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Nowakowski

(a) RESIDENCE NO. 23 Cedar St. St. Ward Curtis Bay, Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S. if of foreign birth? 11 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Helen Nowakowski

6 DATE OF BIRTH (month, day, and year) Not Known

| 7 AGE | Years | Months | Days | IF LESS than 1 day ... hrs. or ... min.. |
|---|---|---|---|---|
| | 35 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Poland

PARENTS

10 NAME OF FATHER Stanislaus Nowakowski

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Helen Nowakowski

(Address) 23 Cedar St

15 Filed ... 19 ... C. HARTMAN JONES M.D. Registrar

Per ...

8-7 1927

Very important. See instructions on back of this sheet.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 5th 1927 19

17 I HEREBY CERTIFY, That I attended deceased from 11-28, 1926, to 2-5-, 1927

that I last saw h[illegible] alive on Feby. 5th, 1927

and that death occurred, on the date stated above, at 2.55 P. m.

The CAUSE OF DEATH* was as follows:

Perforated diverticulitis of Colon.
Diffuse peritonitis.
Pelvic abscess.

(duration) ... yrs. 2 mos 8 ds.

CONTRIBUTORY (Secondary) Intestinal obstruction

(duration) ... yrs. ... mos 2 ds.

18 Where was disease contracted

If not at place of death? ...

Did an operation precede death? yes Date of { 11-28-26 / 12-23-26 / 2-4-27 }

Was there an autopsy? yes

What test confirmed diagnosis? Operation diagnosis

(Signed) Jacob Bernstein, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross — Date of Burial Feb 8 1927

20 UNDERTAKER Grace Funeral Serv — ADDRESS 1906 Edmondson Ave

...ec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 18756 | 10 E 18756

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital 25-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stanley Martuszewski

(a) RESIDENCE NO. 10 Church St. Curtis Bay WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 8 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 21, 1925

7 AGE — Years: 1 | Months: 8 | Days: 16 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Paul Martuszewski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Susy Zuzil

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant (Address): Mrs. Martuszewski 10 Church St

Filed FEB 7 1927 — G. HARRY JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 26, 1927, to Feb 5, 1927, that I last saw him alive on Feb 5, 1927, and that death occurred, on the date stated above, at 5⁰⁰ P m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Intubated Jan 26, 1927 Date of Tracheotomy Feb 5, 1927

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Pos. Culture

(Signed) Myron G Tull M. D.

2/7, 1927 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holly Crosses | DATE OF BURIAL: Feb 7 1927

UNDERTAKER: Frank Crockford | ADDRESS: 1916 Ashland

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

1108.

E 18757

## CERTIFICATE OF DEATH.

129 E 18757.

1-PLACE OF DEATH Mercy Hospital

City of BALTIMORE: (No. 15-56 St., Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Murray

(a) RESIDENCE NO. 4126 Pikesville Rd. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. — mos. ds. — How long in U. S., if of foreign birth? — yrs. — mos. — ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Single |

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 75. | — | — | |

8 OCCUPATION OF DECEASED 045

(a) Trade, profession or particular kind of work Grain and

(b) General nature of industry, business, or establishment in which employed (or employer) Feed Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER James F. Murray

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliza Ann Fitch

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Mrs. Mary T. Barsotti

(Address) 4126 Pikesville Road

15 Filed 1927 C. HARRISON JONES, M.D. Registrar

B-7 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 24 1927, to Feb 5 1927,

that I last saw him alive on Feb 5 1927,

and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis Hypertension

Myocardial Degeneration

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D. S. Motta, M. D.

, 19 (Address) Mercy Hospital City.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fullerton, Md. Date of Burial 2/7 1927

20 UNDERTAKER Henry U. Mears ADDRESS 1805 N. Calvert

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18758 ✓ 179 E 18758

## CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 7-9 Ward)

2-FULL NAME Thomas Orme

(a) RESIDENCE NO. Mt Airey Md. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | col | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mildred Orme

6 DATE OF BIRTH (month, day, and year) unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 33 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer (Common)

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town)_____ (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Orme

11 BIRTHPLACE OF FATHER (city or town)_____ (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Fraser

13 BIRTHPLACE OF MOTHER (city or town)_____ (State or country) Md

14 Informant H. M. Snyder (Address) Mt Airey Md.

15 Filed 7 1927 C. HAMPSON JONES, M. D. Registrar

very important. No

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 7/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Toxemia- 2nd &3rd degree burns over body. Clothing accidently caught fire-probably from lantern he was carrying on Feb 4/27 during ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) (duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. C. Hatton M. D. (Coroner)

2/7/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?_____

Former or usual residence_____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Montgomery Co. Friendship Cem. Date of Burial Feb 9 1927

20 UNDERTAKER J. M. Dutton ADDRESS Md.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18759

CERTIFICATE OF DEATH.

129

E 18759

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospital 16 Ward)

2-FULL NAME William Lucker

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. N. Appleton between Biddle and Monroe Sts Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 53 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Samuel Lucker

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant

(Address) JOHNS HOPKINS HOSPITAL

Filed 1927 C. HAMPSON JONES, M. D.

Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Feb. 2, 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 14, 1927 to Feb. 2, 1927

that I last saw him alive on Feb. 2, 1927

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH was as follows:*

Uremia Lutein [redacted] nephritis

Benign Prostatic Hypertrophy

(duration) ds.

CONTRIBUTORY (Secondary) Renal Suppression

Uremia (duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Course

(Signed) C. Hampson Jones M. D.

19 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 19

20 UNDERTAKER ADDRESS

Commissioner Health. FEB 7 - 1927

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18760

## CERTIFICATE OF DEATH.

90 E 18760

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. 10-15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME A. J. Dane

(a) RESIDENCE NO. 723 Forest St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widowed |

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1847

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 80 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Mass.

PARENTS

10 NAME OF FATHER John Dane

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Mass

12 MAIDEN NAME OF MOTHER Sarah —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Mass

14 Informant

(Address) Records

15 Filed 19

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 5 1927

17

I HEREBY CERTIFY, That I attended deceased from November 5, 1926, to February 5, 1927,

that I last saw him alive on February 5, 1927,

and that death occurred, on the date stated above, at 4.00 P. m.

The CAUSE OF DEATH* was as follows:

Senility,
Cerebral Sclerosis, Chronic Myocarditis
Osteomyelitis left femur & tibia.

(duration) ? yrs. mos. ds.

CONTRIBUTORY Myocardial Failure
(Secondary)

(duration) yrs. 1 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? general appearance

(Signed) R. Hooper Smith, M. D.

Feb. 7 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial 19

20 UNDERTAKER

ADDRESS

Commissioner Health

FEB 7 1927 C. HAMPSON JONES, M. D.

JOHNS HOPKINS HOSPITAL

Spec.—1954 A Co.—

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1954 18761 X 90 E 18761

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 7-9 Ward)

2-FULL NAME Walter Bowlin

(a) RESIDENCE NO. Vanceboro N. Car St. Route 1 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 11-23-1902.

7 AGE: Years 24 Months 2 Days 12 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) N. Car

PARENTS

10 NAME OF FATHER Robert Bowlin

11 BIRTHPLACE OF FATHER (city or town):

(State or country) N. Car

12 MAIDEN NAME OF MOTHER Bessie Hasle

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) N. Car

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed C. HAMPSON JONES, M. D. Registrar

1927 By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 27 Feb. 5

17 I HEREBY CERTIFY, That I attended deceased from Nov. 30, 1926, to Feb. 5, 1927, that I last saw h[illegible]alive on Feb 5, 1927, and that death occurred, on the date stated above, at 10 [illegible] a m.

The CAUSE OF DEATH* was as follows:

Subacute nephritis

(duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Rheumatic heart disease (chronic)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Not confirmed

(Signed) Fullerton Athey, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Grifton N. C. Date of Burial 2/7/27

20 UNDERTAKER: Joseph Ahrens ADDRESS 721 Bway

Spec.—1-10-21 M&T 1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18762

## CERTIFICATE OF DEATH.

57 E 18762

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3009 Littleton Rd. FEB 16 '27 WARD)

2-FULL NAME Matilda Clare Williams

(a) RESIDENCE No. 3009 Littleton St. Rd WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5-6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| ~~Female~~ | White | Widowed |

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of William J Williams

6 DATE OF BIRTH (month, day, and year) Sept 21, 1840

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 86 | 4 | 9 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Theodore Lindauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rachel Hodgkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant W. A. Williams (Address) 3009 Littleton Rd

15 FEB 7 1927 C. HARRISON JONES, M. D. Registrar

P.M.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-5 1927

17 I HEREBY CERTIFY, That I attended deceased from 9-1, 1926, to 2-5, 1927, that I last saw h[illegible] alive on 2-5, 1927, and that death occurred, on the date stated above, at 7:30 P m.

The CAUSE OF DEATH* was as follows:

Diabetes

Myocardial insufficiency

Mitral regurgitation

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) J. H. Brady, M. D.

, 19 (Address) 1403 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Millersville Md

DATE OF BURIAL Feb 8 1927

20 UNDERTAKER Joseph Snyder

ADDRESS 1600 W Mosher Ave

Spec.—1-10-21—M&T—1500 Bks.

18763

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 18763

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 932 N. Fulton Ave. St.) (Ward) 16-22

2-FULL NAME George H. Hooper

(a) RESIDENCE NO. 932 N. Fulton Ave. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widowed |

5a If ~~married~~, widowed, ~~or divorced~~ HUSBAND of (or) ~~WIFE of~~ Mary J. Hooper.

6 DATE OF BIRTH (month, day, and year) Dec. 12-1838

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 88 | 1 | 25 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Semi Artist and Sign Painter

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Cambridge (State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas H. Hooper

11 BIRTHPLACE OF FATHER (city or town) Cambridge (State or country) Maryland

12 MAIDEN NAME OF MOTHER Priscilla Talbot

13 BIRTHPLACE OF MOTHER (city or town) Talbot Co. (State or country) Maryland

14 Informant (Address) Joseph L. Hooper 932 N. Fulton Ave.

15 FEB 7 1927 C. HALPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Febry. 5-1927

17 I HEREBY CERTIFY, That I attended deceased from Nov. 4- 1926. to Febry 5- 1927.

that I last saw h~~im~~ alive on Febry 5- 1927.

and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Uraemia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Chr Parenchymatous Nephritis (duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Lab. & Physical Exam

(Signed) Paul Brown, M. D.

2/6, 1927 (Address) 1837 Penna. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL 2/8- 1927

20 UNDERTAKER H. L. Brannigan & Son — ADDRESS 517 N. ~~St~~

Spec.—6-9-19—H. P. Co.—1000 Blks.

E 18764

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 13764

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Forest Ave Franklintown Rd WARD 26-66

REGISTERED NO. 47

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lizzetta Wallace

(a) RESIDENCE. No. Forest Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Michael Wallace

6 DATE OF BIRTH (month, day, and year) Aug 7-1840

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 86 | 5 | 29 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Ford. Ballauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs. Lizzetta Grauer (Address) Forest Park Ave Franklintown Rd

15 FILED 7 1927 C. HAMPSON JONES, M. D. Registrar By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6 1927

17 I HEREBY CERTIFY, That I attended deceased from July, 1926, to Feb 6, 1927, that I last saw h alive on Feb 6, 1927, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) A. C. Smith, M. D.

Feb 7, 1927 (Address) 4209 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine — DATE OF BURIAL 2/8 — 1927

20 UNDERTAKER H. C. Brownings & Son Schroder 21 ADDRESS 517 N.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

C 18765 E 18765

## CERTIFICATE OF DEATH.

23

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital ST., 19-27 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME McKinley Farrior

(a) RESIDENCE NO. 1721 W. Franklin St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | Married |

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Maiden name unknown

6 DATE OF BIRTH (month, day, and year) Sept. 23, 1902

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 24 | 4 | 12 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedor

(b) General nature of industry, business, or establishment in which employed (or employer) :

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maple Hill N. C

PARENTS

10 NAME OF FATHER Wm Farrior

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. McKinley Farrior

(Address) 1721 W Franklin St

15 Filed 7 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 1 1927, to Feb 4 1927, that I last saw him alive on Feb. 4 1927, and that death occurred, on the date stated above, at 8:00 P m.

The CAUSE OF DEATH* was as follows:

Encephalitis Lethargica

(duration) yrs. mos 18 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical - Lumbar Puncture

(Signed) Myron S. Tull, M. D.

2/16, 1927 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Zion

DATE OF BURIAL 2-8 1927

20 UNDERTAKER Joseph A Lively

ADDRESS 409 N Mount St

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E-18766

## CERTIFICATE OF DEATH.

E 18766

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST. 16-28 WARD

2-FULL NAME Mary Elizabeth Kelly

(a) RESIDENCE NO. 2658 Edmondson Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: John T. Kelly

6 DATE OF BIRTH (month, day, and year): Sept 17-1857

7 AGE: Years 69 Months 4 Days 18 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Robert Emmett Ward

11 BIRTHPLACE OF FATHER (city or town) (State or country): Dublin Ireland

12 MAIDEN NAME OF MOTHER: Catharine Holbrook

13 BIRTHPLACE OF MOTHER (city or town) (State or country): West Ireland

14 Informant: Mt Hope Hosp (Address): Mt Hope Retreat

15 Filed: JAN 7 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 5 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 13, 1925, to Feb 5, 1927, that I last saw h.. alive on Feb 4, 1927, and that death occurred, on the date stated above, at 2.45 a m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(Post Cerebral Hemorrhage)

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary): Senile deterioration

Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Milton P. Ward, M. D.

19 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peter's Cemetery

DATE OF BURIAL: 2/8 1927

20 UNDERTAKER: Chas F. Braun & Son

ADDRESS: 118 W Mt Royal Ave

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18767

## CERTIFICATE OF DEATH.

3/ E 18767

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 822 Rutland Ave St., 7-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Virginia Davis

(a) RESIDENCE NO. 822 Rutland Ave St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? Wayne Pa. yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | col | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joe Davis

6 DATE OF BIRTH (month, day, and year) Unknown 1898

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 27 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) Va.

PARENTS

10 NAME OF FATHER Henry Hunt

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Va

12 MAIDEN NAME OF MOTHER Mary Boswell

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Va.

14 Informant Joe Davis

(Address) 822 Rutland Ave

Very Important. Be sure to answer every question.

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 4/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Pulmonary Tuberculosis

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) C. H. Jones M. D.

(Coroner)

2/7/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Interred Woodlawn 2/7/27

20 UNDERTAKER ADDRESS

Mrs. R. G. Elliott 1225 Eastlawn Ave

Filed 7 1927 C. HAMPSON JONES, M. D.

By_____ Registrar

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18768 E 18768

## CERTIFICATE OF DEATH.

REGISTERED NO. 4341

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) N. S Marine Hosp. ST., Ba. Co. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Olaf Johnson

(a) RESIDENCE NO. Anchorage Hotel ST., WARD — Sweden
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 10 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 14 1871

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 55 | 2 | 22 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor

(b) General nature of industry, business, or establishment in which employed (or employer) AB Seaman

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10 NAME OF FATHER Peter Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Sweden

12 MAIDEN NAME OF MOTHER Christina Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sweden

14 Informant Self
(Address)

15 FEB 7 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov. 27, 1926, to Feb 6, 1927, that I last saw him alive on Feb. 6, 1927, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Acute cardiac dilatation
Pulmonary edema

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Chronic myocarditis, syphilis (duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory and Clinical

(Signed) J. C. Travers, M. D.

, 19 (Address) N. S Marine Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel Cemetery — DATE OF BURIAL: Feb. 8 1927

20 UNDERTAKER: Henry Sander & Sons Inc — ADDRESS: 1710 Fleet St

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 13769 162E 13769

## CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 408 E. Eager ST., 11-15 WARD)

2-FULL NAME Baby Moore

(a) RESIDENCE NO. 408 E. Eager ST., 10 WARD

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. 3 hrs.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Baby.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6 DATE OF BIRTH (month, day, and year): 2/7-27

7 AGE — Years — Months — Days: If LESS than 1 day, 3 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ✓

(b) General nature of industry, business, or establishment in which employed (or employer): ✓

(c) Name of employer: ✓

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): ✓

12 MAIDEN NAME OF MOTHER: Helen Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Mother (Address): Above.

15 2 7 1927 C. HAMPSON JONES, M. D. Registrar

P.M.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/7 1927.

17 I HEREBY CERTIFY, That I attended deceased from 8:30 Am 2/7, 1927, to 11 Am 2/7, 1927, that I last saw h/M alive on 2/7, 1927, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows: Peripneal asphyxia about 3 hrs.

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) C. J. Taylor, M. D.

, 19 (Address) 1752 N. Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cemetery

DATE OF BURIAL: Feb 7 1927

20 UNDERTAKER: George J. Rutt

ADDRESS: 1735 Harford Ave.

Spec.—12-9-25 A Co.—200 Bks.

1991 E 18770

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 E 18770

1-PLACE OF DEATH

REGISTERED NO._____

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 16-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Dorsey

(a) RESIDENCE NO. 920 N. Calhoun St. City Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: col

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 6-23-26.

7 AGE — Years: — Months: 8 — Days: 14 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Baltimore City.

PARENTS

10 NAME OF FATHER Edward Dorsey

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Balto.

12 MAIDEN NAME OF MOTHER Edna Reynolds

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Ga

14 Informant: Records

(Address) JOHNS HOPKINS HOSP

15 Filed 8 1927 G. HALSEY JONES, M. D. Registrar

By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 Feb 7

17 I HEREBY CERTIFY, That I attended deceased from Feb 4, 1927, to Feb 7, 1927, that I last saw h__ alive on Feb 7, 1927, and that death occurred, on the date stated above, at 5 00 a m.

The CAUSE OF DEATH* was as follows:

1st Bronchopneumonia.

(duration) .....yrs. .....mos. 5 ds.

CONTRIBUTORY (Secondary) Pulmonary Tbc - Intestinal Tbc.

(duration) .....yrs. 2 mos. .....ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? no Date of.....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thomas B. Cornell, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem. Date of Burial Feb 8/1927

20 UNDERTAKER: Daniel Easton ADDRESS 916 Eager

Spec.–7-17-26—A Co.—200 Bks.

E 18771

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

14-001

E 18771

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3620 Elm Ave St. 13-52 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida J. Carback

(a) RESIDENCE NO. 3620 Elm Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 10, 1859.

7 AGE — Years: 67 — Months: 11 — Days: 26. — IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer

9 BIRTHPLACE (city or town): md.

(State or country)

PARENTS

10 NAME OF FATHER: John Carback

11 BIRTHPLACE OF FATHER (City or town): md

(State or country)

12 MAIDEN NAME OF MOTHER: Sarah Bevan

13 BIRTHPLACE OF MOTHER (city or town): md

(State or country)

14 Informant: Harry R Fox

(Address) 3620 Elm Ave

15 Filed B - 8 1927 Per

16 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 6, 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 4, 1927, to Feb 6, 1927, that I last saw h... alive on ..., 19..., and that death occurred, on the date stated above, at 930 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) — yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ... yrs. ... mos ... ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. H. Jones, M. D.

, 19 (Address) 850 N. Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Hampden — Date of Burial: Feb 8 1927

20 UNDERTAKER: Chenowet & Son — ADDRESS 3457 Chestnut Ave

Very Important. See instructions on back.

Spec.–7-17-26—A Co.—200 Bks.

Poe

E 18772

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

46

E 18772

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 3456 Hickory Ave. St., 13-58 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adverda L Poe

(a) RESIDENCE NO. 3456 Hickory Ave Ward

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: White

5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emory E Poe

6 DATE OF BIRTH (month, day, and year): March 4 1872

7 AGE: Years 54, Months 11, Days 3. IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) ..... (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town) ..... (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Unknown

14 Informant Emory E Poe (Address) 3456 Hickory Ave

15 Filed FEB 6 1927 C. HARRISON JONES Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1927, to Feb. 7, 1927, that I last saw h[illegible] alive on Feb. 7, 1927, and that death occurred, on the date stated above, at 930 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) E. F. [illegible], M. D.

2/9, 1927 (Address) 3701 Reisterstown Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Hampden — Date of Burial: Feb 9 1927

20 UNDERTAKER: Chenoweth & Son — ADDRESS 3617 Chestnut Ave

Very Important. See Instructions on Back of Certificate

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18773

CERTIFICATE OF DEATH.

117

E 18773

REGISTERED NO.

1-PLACE OF DEATH Mercy Hospital

City of BALTIMORE: (No. ____ St. 17-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Ellison

(a) RESIDENCE NO. 1303 Argyle ave. — St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ____

6 DATE OF BIRTH (month, day, and year) ____ 1880

7 AGE: Years 47 | Months | Days | IF LESS than 1 day ____hrs. or ____min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Day Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Odd

(c) Name of employer

9 BIRTHPLACE (city or town) ____ (State or country) N. C.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) ____ (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ____ (State or country) Unknown

14 Informant Edna McIntosh (Address) 1303 Argyle Ave

15 Filed ____ 19 ____ ____ Registrar

FEB 8 1927 REGISTRAR'S OFFICE

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-5 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 27, 1926, to Feb 5, 1927, that I last saw h. alive on Feb 5, 1927, and that death occurred, on the date stated above, at 6 Hr 4 m.

The CAUSE OF DEATH* was as follows:

Appendiceal Abscess

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Infarct of Lung & Pulmonary Hemorrhage

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? ____

Did an operation precede death? Yes Date of 12/29/'26

Was there an autopsy? ____

What test confirmed diagnosis? ____

(Signed) C. Smith M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary — Date of Burial: Feb 8 1927

20 UNDERTAKER: John H. Soader — ADDRESS 1027 Hanover

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18774

# CERTIFICATE OF DEATH

101-001

E 18774

1-PLACE OF DEATH

REGISTERED NO. 2129

City of BALTIMORE: (No. 1256 Carroll St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gerald L. Roberts

(a) RESIDENCE NO. 1256 Carroll St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug. 10, 1919

7 AGE: Years 7 Months 5 Days 27

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER Frank W. Roberts

11 BIRTHPLACE OF FATHER (City or town) Balto. Md.

(State or country)

12 MAIDEN NAME OF MOTHER Virginia Mc Closkey

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant Mrs. Frank Roberts

(Address) 1256 Carroll St.

Filed FEB - 8 1927 19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 2, 1927 to Feb 6, 1927

that I last saw him alive on Feb 6, 1927 at 10.02 p.m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH was as follows:

Cardiac Arrhythmia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Blue Lindsay

(Signed) Phil. H. Claussen M. D.

19 (Address) 17 New Cross Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem.

Date of Burial: 2/9 1927

20 UNDERTAKER: Margaret S. Flynn

ADDRESS: 1411 Light St

C. HAMPSON JONES, M. D.

rev.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18775

E 18775

## CERTIFICATE OF DEATH.

E 18775
1-PLACE OF DEATH

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 3316 Elmora Ave ST. 8-40 WARD

2-FULL NAME Elisha D. O. Davis, Sr

(a) RESIDENCE NO. 3316 Elmora Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | married |

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah E. Davis

6 DATE OF BIRTH (month, day, and year) March 12-1857

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 69 | 10 | 26 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Can Capper
(b) General nature of industry, business, or establishment in which employed (or employer) Retired
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS
10 NAME OF FATHER Wm. Davis
11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.
12 MAIDEN NAME OF MOTHER Susanna M. Gray
13 BIRTHPLACE OF MOTHER (City or town) (State or country) Baltimore Md

14 Informant Sarah E. Davis
(Address) 3316 Elmora Ave

15 Filed FEB 8 1927 C. HALTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1926, to Feb 7, 1927, that I last saw h[illegible] alive on Feb 6, 1927, and that death occurred, on the date stated above, at 11.40 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) yrs. 4 mos 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) Thos Fe Jenkins, M. D.
2/8, 1927 (Address) 2878 Walford Rd.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemt.
DATE OF BURIAL 2/9/1927

20 UNDERTAKER Zirkler & Zirkler
ADDRESS 2220 E Eager St

Spec.—7-17-26—A Co.—200 Blks.

E 18776

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

90

E 18776

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 2129 Callow Ave St., 13-59 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ada Long Pinto

(a) RESIDENCE NO. 2129 Callow Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Samuel Pinto

6 DATE OF BIRTH (month, day, and year): June 3. 1857

7 AGE — Years: 69 Months: 7 Days: 3 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town): Princess Anne

(State or country): Md.

PARENTS

10 NAME OF FATHER: Edward Long

11 BIRTHPLACE OF FATHER (City or town): unknown

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Aurelia Pouch

13 BIRTHPLACE OF MOTHER (city or town): unknown

(State or country): Md.

14 Informant: Lydia E. Long

(Address): 2129 Callow Ave.

Filed FEB - 8 1927 19 Per H. HARRISON JONES, M. D. Registrar

R.K.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 6 19 27

17 I HEREBY CERTIFY, That I attended deceased from about Nov 1, 1926, to Feb 6, 1927, that I last saw her alive on Feb 5, 1927 and that death occurred, on the date stated above, at 12.15 a m.

The CAUSE OF DEATH* was as follows:

Cardiac hypertrophy from mitral insufficiency

(duration) several yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

Uraemia (duration) yrs. mos. 6 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. R. Wrangel M. D.

2/8, 19 27 (Address) 1014 S. Ellwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Princess Anne Md. Date of Burial: Feb 9 1927

20 UNDERTAKER: Wm J Tucker Sons ADDRESS: Montpelier

Very Important. Use Typewriter or Pen and Ink.

Spec.—1-10-21—M&T—1500 Bks.

E 18777

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18777

99-002

## CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 16 N. Linwood Ave ST. 6-11 WARD)

2-FULL NAME John Langkamp

(a) RESIDENCE NO. 16 N. Linwood ave ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 84 yrs. ... mos. ... ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced
~~HUSBAND OF~~
(or) WIFE of Sophia Langkamp

6 DATE OF BIRTH (month, day, and year) April 27th 1840

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 86 | 9 | 9 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Langkamp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Leroy C. Langkamp
(Address) No 82 Rogers ave

15 Filed - 8 1927. 16 C. HAMPSON JONES, M. D. Registrar
By R.K.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5th 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 29th 1926 to July 5th 1927.
that I last saw him alive on July 4th 1927.
and that death occurred, on the date stated above, at 1128 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary oedema

(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) Senile age. Chronic Bronchitis (duration) ... yrs. ... mos. 7 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) ..... M. D.

7/6, 19 (Address) 15 N. Eden St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL July 7 1927

20 UNDERTAKER George Schilling & Sons

ADDRESS 1120 E. Monument

Cor.—12-9-25—A Co.—200 Bks.

18778

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129

REGISTERED No. E 18778

1-PLACE OF DEATH

City of BALTIMORE: (No. 2105 Eutaw St. 12-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Adolph Vogin

(a) RESIDENCE NO. 2105 E Eutaw St. Ward Pennsylvania

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1895

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| about 32 | | | | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer) Bethlehem Steel
(c) Name of employer

9 BIRTHPLACE (city or town) Pennsylvania
(State or country)

PARENTS

10 NAME OF FATHER not known

11 BIRTHPLACE OF FATHER (city or town)
(State or country) not known

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) not known

14 Informant W. M. E. Beard
(Address) Sparrows Point Md.

15 Filed 8 1927 19 C. HARRISON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/6/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage 24 hrs
Chronic Interstitial Nephritis 1 yr

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) Chas. E. Beacham M. D.
(Coroner)

, 19 (Address) 3325 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: HOLY REDEEMER — Date of Burial: Feb. 8. 1927

20 UNDERTAKER: John Greblia[illegible] L. G. — ADDRESS: 423 S Paca St.

ec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

18779

## CERTIFICATE OF DEATH.

90 E 18779

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1502 N Rose ST. 8-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Kelly

(a) RESIDENCE NO. 1502 N Rose ST., 6 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? 54 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | White | Married |

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Margreth Kelly

6 DATE OF BIRTH (month, day, and year) July 17 1861

7 AGE

| Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|
| 66 | 6 | 7 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor

(b) General nature of industry, business, or establishment in which employed (or employer) for U. S. N.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Erland

PARENTS

10 NAME OF FATHER William Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Erland

12 MAIDEN NAME OF MOTHER Cathrine Bryan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Erland

14 Informant Margreth Kelly (Address) 1502 N Rose

15 Filed FEB - 8 1927 C. HEATON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 6, 1927, to Feb 7, 1927, that I last saw h[illegible] alive on Feb 7, 1927, and that death occurred, on the date stated above, at 12-25 PM

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Finding

(Signed) Theo Bunyea, M. D.

7, 19 27 (Address) 800 N Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL February 10 1927

20 UNDERTAKER Wendell Diffel & Son

ADDRESS 378 Dean

Spec.-7-17-26—A Co.—200 Bks.

E 18780

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18780

## CERTIFICATE OF DEATH

129

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 604 Cornell St. 22-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susie Young

(a) RESIDENCE NO. 604 Cornell St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. — mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William Young

6 DATE OF BIRTH (month, day, and year): 1869

7 AGE: Years 64 Months + Days +

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Bryn Mawr College, Essex Co.

9 BIRTHPLACE (city or town):

(State or country) Virginia

PARENTS

10 NAME OF FATHER Henry Thornton

11 BIRTHPLACE OF FATHER (City or town) Essex Co

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Martha Wyatt

13 BIRTHPLACE OF MOTHER (city or town) Essex Co

(State or country) Virginia

14 Informant: Martha Watts

(Address) 604 Cornell St

FEB 8 1927

15 Filed [illegible] Registrar

Per [illegible]

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/5/1927

17 I HEREBY CERTIFY, That I attended deceased from 1/17, 1927, to 2/5, 1927, that I last saw her alive on 2/4, 1927, and that death occurred, on the date stated above, at 3:30 a.m.

The CAUSE OF DEATH* was as follows:

Hemiplegia,

(Uraemia)

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) Chr. nephritis & Arteriosclerosis

(duration) unknown mos. do.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Dan'l Drucker, M. D.

2/7, 1927 (Address) 122 N Eden St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

Date of Burial 2/8 1927

20 UNDERTAKER: Mrs Jas A Hooper

ADDRESS 406 N Carey St

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18781

## CERTIFICATE OF DEATH.

44 E 18781

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4001 Belview Ave. ST.) 15-63 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane E. Greer

(a) RESIDENCE NO. 4001 Belview Ave. ST.; WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | white | widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John A. Greer

6 DATE OF BIRTH (month, day, and year) ccakumm

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 76 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John F. Pope

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Caroline

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Milton G. Greer

(Address) 4001 Belview Ave.

15 Filed FEB 8 1927 19 H. HALL BROWNE, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5 1927

17

I HEREBY CERTIFY, That I attended deceased from January 18. 1927 to February 5. 1927.

that I last saw her alive on February 5. 1927.

and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

diabetes

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) probably cancer of the stomach (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinary

(Signed) Thos Dulany Thomas, M. D.

, 19 (Address) 330 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Frederick, Md. Mt. Olivet Cemetery DATE OF BURIAL Feb. 9, 1927

20 UNDERTAKER John C. Mitchell ADDRESS 1900 E. Baltimore St.

Spec.—1-10-21—M&T—1500 Bks.

E 18782 HEALTH DEPARTMENT—CITY OF BALTIMORE E 18782

# CERTIFICATE OF DEATH

74-007

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hosp. 25-75 ST., WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest Jasper

(a) RESIDENCE NO. 319 Patapsco Ave. ST., ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Ernest Jasper

6 DATE OF BIRTH (month, day, and year) Dec. 18, 1877

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs. or ....min. |
|---|---|---|---|---|
| | 50 | 1 | 20 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Dante, (State or country) Virginia

PARENTS

10 NAME OF FATHER David Jasper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Ella Cobbs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records

(Address)

Filed Feb 8 1927 C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb 3 1927, to Feb 6 1927,

that I last saw h(e) alive on Feb 6 1927,

and that death occurred, on the date stated above, at 6:10 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) Chas A. Longwell M. D.

(Address) 1 W Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel

DATE OF BURIAL Feb 9 1927

20 UNDERTAKER John Ulrich

ADDRESS 8 E Lanvale

Spec.–7-17-26—A Co.—200 Bkn.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18783

## CERTIFICATE OF DEATH

101,001

E 18783

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1216 1 Sharp St. 23-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cosmo Robb

(a) RESIDENCE NO. 1216 1 Sharp St. 23 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Virginia Robb

6 DATE OF BIRTH (month, day, and year): July 28 1896

7 AGE: Years 30 Months 7mos Days 8

IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer): Stevedore

(c) Name of employer: Wharfes

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Jacob Robb

11 BIRTHPLACE OF FATHER (City or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Sarah Robb

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Sarah Wiles

(Address) 1216 S Sharp St.

15 Filed ....., 19.. C. HARDEN JONES M. D. Registrar

8 - 8 1927 Kf

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/6/1927

17 I HEREBY CERTIFY, That I attended deceased from 2/1/27 to 2/6/27.

that I last saw h— alive on 2/5/27.

and that death occurred, on the date stated above, at 5.00 A m.

The CAUSE OF DEATH* was as follows:

Double Lobar Pneumonia

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Chronic Recurrent Bronchitis (duration) about yrs. mos 23 ds.

18 Where was disease contracted

If not at place of death? No

Did an operation precede death? No Date of —

Was there an autopsy? Negi

What test confirmed diagnosis? Clinical

(Signed) J. Harry Bowley M. D.

2/6/1927 (Address) 908 Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion — Date of Burial Feb 9 1927

20 UNDERTAKER: R L Parham — ADDRESS 1216 S. Sharp st

Spec.—12-9-25—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 18784

REGISTERED NO. 31 E 18784

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. (No.) 10.37 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME JOSEPH LAPPIN 53 Years

(a) RESIDENCE NO. C/o British Consul St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Married |

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown 1879

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 47 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) D. S. Stern

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) England

PARENTS

10 NAME OF FATHER William Lappin

11 BIRTHPLACE OF FATHER (city or town)

(State or country) England

12 MAIDEN NAME OF MOTHER Jane Giskin

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) England

14 Informant Hospital Records

(Address)

Filed FEB 8 1927. C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

February 6, 1927.

17

I HEREBY CERTIFY, That I attended deceased from December 2, 19 26, to February 6, 19 27,

that I last saw him alive on February 6, 19 27,

and that death occurred, on the date stated above, at 9.15 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. E. Gatewood, M. D.

2-7-27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery Date of Burial Feb. 8 " 27

20 UNDERTAKER Dept & Cook ADDRESS 1002 W. Balto St

Spec.—1-10-21—M&T—1500 Bks.

8785

# HEALTH DEPARTMENT—CITY OF BALTIMORE

1001

100 E 18785

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1908 Ramsay ST. 20-28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edna Mae Cole

(a) RESIDENCE NO. 1908 Ramsay ST., ..... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| F | W. | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Jan 4 1927

6 DATE OF BIRTH (month, day, and year)

| 7 AGE Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|
| | 1 | 5 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Edward Cole

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ethel McCorkle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Edward J. Cole

(Address) 1908 Ramsay St

15 Filed FEB 8 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 3, 1927, to Feb. 6, 1927.

that I last saw h[illegible] alive on Feb 6, 1927.

and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. W. Hammond M. D.

2-7, 1927 (Address) 3012 Garrison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Feb 9 1927

20 UNDERTAKER Wm Cook — ADDRESS 507 E North Ave

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

18786

## CERTIFICATE OF DEATH.

16-23

90 E 18786

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1224 W. Lanvale St. _____ Ward)

2-FULL NAME Lillie A. Ferrell

(a) RESIDENCE NO. 1224 W. Lanvale St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 5 mos. 7 ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) Aug 7 1863

| 7 AGE 63 | Years | Months | Days 20 | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 64 | 5 | 7 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Balt

(State or country) Md

PARENTS

10 NAME OF FATHER Thomas Ferrell

11 BIRTHPLACE OF FATHER (city or town) Balt

(State or country) Md

12 MAIDEN NAME OF MOTHER Christiana Baird

13 BIRTHPLACE OF MOTHER (city or town) Balt

(State or country) Md

14 Informant Mrs. Fannie B. McClellon

(Address) 1224 W. Lanvale St.

B. - FEB 8 1927 - H. JONES, M. D.

P. _____ Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Feb. 7, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said _____ (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

_____ (duration) 1 yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) No history

_____ (duration) ___ yrs. ___ mos. ___ ds.

(Signed) J. T. Hennessy M. D.

(Coroner)

Feb 8 1927 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gramont Cem

Date of Burial Feb 9th 1927

20 UNDERTAKER E. Barron Bennett

ADDRESS 733 W. Lafayette Ave

Cor.—12-9-25—A Co.—200 Bks.

Martin Sawyer

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 18787

E 18787

## CERTIFICATE OF DEATH.

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 1112 Burgundy St. 7-1-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martin Sawyer

(a) RESIDENCE NO. 1112 Burgundy St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 7 24

7 AGE: Years 3 Months 1 Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Balt

(State or country)

PARENTS

10 NAME OF FATHER Clifton Sawyer

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balt

12 MAIDEN NAME OF MOTHER Lily Saulsbury

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balt

14 Informant (Address) Clifton Sawyer 1112 Burgundy St.

15 Filed 8 1927 6. HARRISON JONES, M. D. Registrar

By R.M.

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/7 192/

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows: Lobar Pneumonia

(duration) .....yrs. 4 mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) Harris D Wilson M. D.

(Coroner)

, 192 (Address) 332 S Paca St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cem. Date of Burial: Feb 9 1927

20 UNDERTAKER: Chas W. Dill. ADDRESS 3109 Fredk Ave.

pec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18788

## CERTIFICATE OF DEATH.

65-002

E 18788

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1419 Battery ST. 24-23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman W. Posel

(a) RESIDENCE NO. 1419 Battery ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. 0 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male. | white | Married |

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Maud M. Posel

6 DATE OF BIRTH (month, day, and year) Jan 18 1895

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 32 | 0 | 19 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer Odd

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Gustav Posel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Ernes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs Posel

(Address) 1419 Battery

Filed FEB 8 1927 HALTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-7 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 3, 1926, to Feb 7, 1927, that I last saw h[illegible] alive on Feb 7, 1927 and that death occurred, on the date stated above, at 1 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary disease

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Exam

(Signed) [illegible] M. D.

Feb, 1927 (Address) 130 Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| J. Faw McCully | 130 Feb 1927 |
| 20 UNDERTAKER | ADDRESS |
| Cedar Hill | 19-27 |

pec.—1-12-23—M&T—500 Blks.

E 18789

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

59-002

E 18789

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 121 E 6 Clement ST. (WARD) 24-33

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Dallmas

(a) RESIDENCE NO. 121 E 6 Clement ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male. | white | Single |

6 If married, widowed, or divorced HUSBAND of (or) WIFE of —

7 DATE OF BIRTH (month, day, and year) 2-1-1927

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min |
|---|---|---|---|---|
| | — | — | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. bb

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John F. Dallmas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Dora B. Conway

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Dallmas (Address) 121 E. 6 St.

15 Filed 2-8 1927 E. HALTON JONES, M. D. Registrar RK

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-7 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1927, to Feb 7, 1927, that I last saw her alive on Feb 7, 1927 and that death occurred, on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Congenital Valvular Heart disease

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm. Stifler, M. D.

2/8, 1927 (Address) 1219 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem

DATE OF BURIAL 2/8 1927

20 UNDERTAKER S. Frank McCully

ADDRESS 13 . . Balto

Spec.—12-9-25—A Co.—200 Bks.

E 18790

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1/161-00 E 18790

1-PLACE OF DEATH Church Home & Infirmary 5

City of BALTIMORE: (No. 1 Broadway St., 8th Ward)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Hanson

(a) RESIDENCE NO. 3229 Abell Ave St. Md Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb. 8, 1927

7 AGE — Years | Months | Days | IF LESS than 1 day ...hrs. or ...min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md

(State or country)

PARENTS

10 NAME OF FATHER C. Albert Hansen

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Norway

12 MAIDEN NAME OF MOTHER Ethel Dorf

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Phila. Pa

14 Informant C. Albert Hansen

(Address) 3229 Abell Ave

15 Filed ... 19 ... C. [illegible] JONES, M. D. Registrar.

By ...

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 8, 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb 7th, 1927, to Feb 8th, 1927, that I last saw him alive on Feb 8th, 1927, and that death occurred, on the date stated above, at 1:30 a. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Atelectasis

(duration) ...yrs. ...mos. 11 hrs.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. H. McCracken, M. D.

, 19 (Address) Church Home & Inf. Balt.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Date of Burial Feb 8 1927

20 UNDERTAKER: Robert L. Tillo ADDRESS: 1730 Eastern

FEB 8 1927

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18791

E 18791

## CERTIFICATE OF DEATH.

181-004

REGISTERED NO. 15-63

1-PLACE OF DEATH

City of BALTIMORE: (No. 4500 Garrison Av. St., 15 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Serio

(a) RESIDENCE NO. 4500 Garrison Av. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine Serio

6 DATE OF BIRTH (month, day, and year) Dec 27 98

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 27 | 1 | 10 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fruit Dealer

(b) General nature of industry, business, or establishment in which employed (or employer) Market Stall

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Italy

PARENTS

10 NAME OF FATHER Joseph Serio

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Italy

12 MAIDEN NAME OF MOTHER Giglio

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Italy

14 Informant Antonio Serio

(Address) 4500 Garrison Av.

Filed B-8 1927 C. HAMPTON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 6, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to h... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carbon Monoxide Poisoning (Accidental) Found dead in automobile

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) J. S. Hagerman, M. D. (Coroner)

Feb. 7, 1927 (Address) 702 Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery Date of Burial: Feb 9 1927

20 UNDERTAKER W. J. Poulton ADDRESS 2238 N. Howard

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18792

## CERTIFICATE OF DEATH.

E 18792

REGISTERED NO. 129

1-PLACE OF DEATH

City of BALTIMORE: (No. 323 N Fremont St. 4th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Raglan Woodson

(a) RESIDENCE NO. 323 N Fremont St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | col | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Lucy Ann Woodson

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 66 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Russell Co.

(State or country) Va.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) unknown

14 Informant Woodson

(Address) 323 N Fremont St

15 Filed 19 Registrar

8-8 1927 K.K.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-6-1927

17 I HEREBY CERTIFY, That I attended deceased from 1-29-1927, to 2-6-, 1927, that I last saw h~~e~~im alive on 2-6-, 1927, and that death occurred, on the date stated above, at 5:45 p.m.

The CAUSE OF DEATH* was as follows: Chronic interstitial nephritis,

(duration) about yrs. 12 mos. ds.

CONTRIBUTORY (Secondary) Chronic myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R. E. Hayburn, M. D.

2-7-1927 (Address) 1808 W Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery — Date of Burial Feb 9, 1927

20 UNDERTAKER Mrs. Katie R. Williams — ADDRESS 322 N. Schroeder St

# HEALTH DEPARTMENT---CITY OF BALTIMORE

100-001

E 18793

## CERTIFICATE OF DEATH

E 18793

1 PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 11 E. Saratoga St. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Thomas Holden Ward

(Residence in Baltimore: No. 11 E. Saratoga St. St.; ..... yrs. ..... mos. ..... ds.)

### PERSONAL AND STATISTICAL PARTICULARS

| 3-SEX | 4-COLOR OR RACE | 5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) |
|---|---|---|
| Male | colored | child |

6-DATE OF BIRTH: Sept 11 (Month) ..... (Day), 1926 (Year)

7-AGE: ..... yrs. 4 mos. 27 ds. If LESS than 1 day, ..... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE (State or country) Baltimore Md

PARENTS

10-NAME OF FATHER Holden Ward

11-BIRTHPLACE OF FATHER (State or country) Gloucester, Va.

12-MAIDEN NAME OF MOTHER Arinta Mitchell

13-BIRTHPLACE OF MOTHER (State or country) Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Holden Ward

(Address) 11 E. Saratoga St.

15- Feb 8 1927 C. HARRISON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Feb (Month) 8 (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 7, 1927, to Feb 8, 1927, that I saw h... alive on Feb 7, 1927, and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

..... (Duration) ..... yrs ..... mos. 4 ds.

Contributory (SECONDARY) .....

..... (Duration) ..... yrs ..... mos. ..... ds.

(Signed) W K Forrest M D

2-8, 1927. [Address] 117 W. Saratoga St

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Mt. Lebanon Cemetery

DATE OF BURIAL: Feb 9, 1927

20-UNDERTAKER: Mrs. Katie R. Williams

ADDRESS 322 N. Wheeler St

# HEALTH DEPARTMENT--CITY OF BALTIMORE

18794

## CERTIFICATE OF DEATH

31 E 18794

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No St. Elizabeths' Home (or WARD) 9-47

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Irene Fenwick

(Residence in Baltimore: No. St. Elizabeths' Home Chesnut Hill ave St.; yrs. mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: negress

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word):

6 DATE OF BIRTH: October (Month) 20 (Day), 1925 (Year)

7 AGE: 1 yrs. 3 mos. 16 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work:
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (State or country): "

12 MAIDEN NAME OF MOTHER: Julia Fenwick

13 BIRTHPLACE OF MOTHER (State or country): Balto. Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Filed 8 1927 C. HAMPSON JONES, M. D. REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: February (Month) 6 (Day), 1927 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 12, 1927, to February 6 1927 that I saw h[illegible] alive on February 5, 1927 and that death occurred, on the date stated above, at 8.45 P m.

The CAUSE OF DEATH* was as follows:

Tuberculor Pneumonia

(Duration) yrs. mos. 4 ds

Contributory (SECONDARY): Varicella

(Duration) yrs. mos. ds.

(Signed) Frank Ayd M. D.

Feb 7, 1927 (Address) 2605 E. Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: HOPKINS HOSPITAL DATE OF BURIAL ,191

20 UNDERTAKER: Com Dissioner Health. ADDRESS FEB 8 - 1927

1020

is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 18795

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

161-006 E 18795

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 638 W Lombard St., 4 30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Applegarth

(a) RESIDENCE NO. 638 W Lombard St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): 1-31-27

7 AGE — Years: — Months: — Days: 7 6

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer:

9 BIRTHPLACE (city or town): Balto

(State or country):

PARENTS

10 NAME OF FATHER: not known Applegarth

11 BIRTHPLACE OF FATHER (city or town): Balto

(State or country) Md

12 MAIDEN NAME OF MOTHER: Bessie Burkhart

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country) Md

14 Informant .....

(Address) .....

15 Filed 8 1927 C. HAMPSON JONES, M. D.

By ..... Registrar

very important. See instructions on reverse side.

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 2/7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Premature Infant

26 wks Gestation

Immediate (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY* (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) Samuel A Disney M. D.

(Coroner)

, 19 27 (Address) 5325 Park Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

JOHNS HOPKINS HOSPITAL

FEB 8 1927

Commissioner Health.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 18796

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

179 E 18796

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1555 Carrell ST. 9-46 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Agnes Brady

(a) RESIDENCE. No. 1555 Carrell ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female.

4 COLOR OR RACE White.

5 Single, Married, Widowed, or Divorced (write the word) Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas James Brady.

6 DATE OF BIRTH (month, day, and year) Oct. 1. 1873

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 53 | 4 | 4 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife. 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Michael J. Roddy.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Mary Money

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Simpson

(Address) 1773 Montpelier St.

Filed AUG 8 1927 C. HAMPSON JONES, M. D., Registrar

Per ADS

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 19. 1926. to Feb 5. 1927.

that I last saw her alive on Feb 6. 1927.

and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Bright's Disease

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Anemia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? D. —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinic

(Signed) C. Winfield M. D.

2/7. 1927 (Address) 1777 Bellona Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL 2/9/27

20 UNDERTAKER Mary M. Wiedefeld.

ADDRESS 501 E. Mad St.

Spec.-7-17-26—A Co.—200 Bks.

E 18797

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

X 31 E 18797

REGISTERED NO. _____

1-PLACE OF DEATH

City of BALTIMORE: (No. 417 W Barre St. 22-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Onley Pryor

(a) RESIDENCE NO. 417 W Barre St. Ward Prospect Va

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 11 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Col | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) 1844

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..hrs. or ..min.. |
|---|---|---|---|---|
| | 33 | + | + | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work R. R. Hand

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer —

9 BIRTHPLACE (city or town) Prince Edward Co

(State or country) Virginia

PARENTS

10 NAME OF FATHER Randolph Pryor

11 BIRTHPLACE OF FATHER (City or town) Buckingham

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Rebecca Gray

13 BIRTHPLACE OF MOTHER (City or town) Prince Ed Co.

(State or country) Virginia

14 Informant Ed Scott

(Address) 417 W Barre St

15 Filed 8 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/7 1927

17 I HEREBY CERTIFY, That I attended deceased from 1/24 1927 to 2/7 1927

that I last saw him alive on 2/7 1927

and that death occurred, on the date stated above, at 6:50 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

(duration) — yrs. 8 mos. — ds.

CONTRIBUTORY (Secondary) _____

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis? _____

(Signed) David Frankel M. D.

2/8 1927 (Address) 142 W Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Prospect Va — Date of Burial 7, 8, 1927

20 UNDERTAKER Mrs Geo H Hooper — ADDRESS 406 W Conway St

very important. See instructions on back of

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18798 — CERTIFICATE OF DEATH. — E 18798

1-PLACE OF DEATH 955 N. Chapel St

CITY OF BALTIMORE: (No. 7 ST., 7-13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Perry

(a) RESIDENCE NO. 955 N. Chapel St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma Perry

6 DATE OF BIRTH (month, day, and year): Aug 3, 1888

7 AGE — Years: 38 — Months: 6 — Days: 1 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer): Bethlehem

(c) Name of employer: Steel Co

9 BIRTHPLACE (city or town) (State or country): N. C.

PARENTS

10 NAME OF FATHER: Allen Perry

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. C.

12 MAIDEN NAME OF MOTHER: Patty Perry

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. C.

14 Informant (Address): Emma Perry 955 Chapel St.

15 2 8 1927 C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 4 1927

17

I HEREBY CERTIFY, That I attended deceased from 2-3, 1927, to 2-4, 1927, that I last saw h— alive on 2-4, 1927, and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Acute Congestion Pneumonia

Pulmonary Edema.

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W B Butler, M. D.

, 19 (Address) 925 N. Carlin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Frankline N.C.

DATE OF BURIAL: 2/8/27

20 UNDERTAKER: Mrs. R. A. Elliott

ADDRESS: 1725 Ashland

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE (Leitch) ✓

CERTIFICATE OF DEATH.

84 E 18799

REGISTERED NO.

E 18799

1-PLACE OF DEATH

City of BALTIMORE: (No. 657 W Saratoga St. 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Leitch

(a) RESIDENCE NO. 657 W Saratoga St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred not Prev yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | W | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Leitch

6 DATE OF BIRTH (month, day, and year) not Prev

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| Abt | 65 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ireland

(State or country)

PARENTS

10 NAME OF FATHER not known

11 BIRTHPLACE OF FATHER (city or town)

(State or country) not known

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Felix Leitch

(Address) 657 W Saratoga

15 8 1927 C. HAMPSON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Angina Pectoris

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Prostatectomy

(duration) yrs. mos. ds.

(Signed) (Coroner) M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem Date of Burial 2/9 192

20 UNDERTAKER Felix A Foley ADDRESS Fulton & Fayette

ec.—1-12-23—M&T—500 Bks.

E 18800

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18800

## CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1019 W Lombard (ST.) 18-29 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Lankau

(a) RESIDENCE NO. 1019 W Lombard ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: August Lankau

DATE OF BIRTH (month, day, and year): Dec 24 1837

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 89 | 1 | 14 | |

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country): Germany

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

PARENTS

14 Informant: Mrs Lena Lankau

(Address) 1019 W Lombard

15 Filed 8 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/6 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1927, to Feb 6, 1927.

that I last saw h[illegible] alive on Feb 6, 1927

and that death occurred, on the date stated above, at 12 noon.

The CAUSE OF DEATH* was as follows:

Hemiplegia 6 days

Chronic Nephritis 2 years.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Hebber Hemmeter M. D.

2/8, 1927 (Address) 2000 Hallows Ct

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem

DATE OF BURIAL: 2/9 1927

UNDERTAKER: Joseph A Tally

ADDRESS: Fulton & Fayette

Spec.—1-10-21—M&T—1500 Bks.

St. Ed Grumpled

18801

# HEALTH DEPARTMENT—CITY OF BALTIMORE

18801

## CERTIFICATE OF DEATH.

125

1-PLACE OF DEATH

CITY OF BALTIMORE. No. 426 Fremont St., 20th WARD.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Elizabeth Keller

(a) RESIDENCE No. 426 Fremont St., 20th WARD

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. 10 mos. 20 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If non-resident give City or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Nicholas Keller

6 DATE OF BIRTH (month, day, and year): Mar 11th 1880

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 46 | 10 | 20 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country): Ballo. Md.

PARENTS

10 NAME OF FATHER: Henry Meier

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth Hunbach

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Germany

14 Informant: Nicholas Keller

(Address) 426 Fremont St.

15 1927 C. HAMPSON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 14, 1927, to Feb 6, 1927.

that I last saw he/she alive on Feb 5, 1927.

and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) — yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary): Nephritis

(duration) — yrs. — mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) [illegible], M. D.

2/6/1927 (Address) 514 London

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Feb 9th 1927

UNDERTAKER: H.S. Wilfert

ADDRESS: 1850 N. Ave

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 18802 | E 18802

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hosp. St., 4-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Ward.

(a) RESIDENCE NO. Woodstock Md. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 dys. How long in U. S. if of foreign birth? yrs. mos. da.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | Col | S. |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day and year) May 16, 1913

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 14 | 8 | 23 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Woodstock

(State or country)

PARENTS

10 NAME OF FATHER Walter Ward

11 BIRTHPLACE OF FATHER (City or town) Unknown

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown

(State or country)

14 Informant Hospital Records.

(Address)

15 Filed FEB 9 1927 C. HAMPSON JONES, M. D. Registrar

Per K.A.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 8 1927.

17 I HEREBY CERTIFY, That I attended deceased from Feb. 7, 1927, to Feb 8, 1927

that I last saw him alive on Feb 8, 1927

and that death occurred, on the date stated above, at 5 30 P m.

The CAUSE OF DEATH* was as follows:

1 Acute Pneumococcic Meningitis

1 Other Medical

(duration) yrs. mos 5 da.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy.

(Signed) Ekmelet, M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Howard Co Mt. View Cem.

Date of Burial Feb. 10 1927

20 UNDERTAKER Easton Bros

ADDRESS Ellicott City

Spec. 1-10-21 M&T 1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18803

## CERTIFICATE OF DEATH.

90

E 18803

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1159 Washington Blvd ST. 21-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Allbright

(a) RESIDENCE NO. 1159 Washington Blvd ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jessie Allbright

6 DATE OF BIRTH (month, day, and year) Sept 5 1865

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 61 | 5 | 2 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Louis Adenthall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Jessie Allbright

(Address) 1159 Washington Balto

Filed FEB 9 1927 E. PARKE JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 29, 1927, to Feb 7, 1927.

that I last saw her alive on Feb 6, 1927.

and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Erysipelas

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) Chr. Endocarditis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. M. Dellcroll, M. D.

Feb 8, 1927 (Address) 621 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet DATE OF BURIAL Feb 10 1927

20 UNDERTAKER John J. Fields ADDRESS 1200 W Lombard

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18804

## CERTIFICATE OF DEATH.

90 E 18804

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2403 Shirley Ave St., 15-56 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillian R. Baum

(a) RESIDENCE NO. 2403 Shirley Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | W | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emanuel Baum

6 DATE OF BIRTH (month, day, and year) March 14 — 1891

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 35 36 | 10 | 23 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER William Scheer

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Hintzen

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant E. Baum

(Address) 2403 Shirley Ave

15 Filed Feb 9, 1927 H. BALTON JONES, M. D. Registrar

Per K.K.

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/5/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to her death on the date stated above.

The CAUSE OF DEATH* was as follows: Valvular disease of heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Harry Morrison M. D. (Coroner)

2/8/ 1927 (Address) 9632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the state yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Hebrew Cem

Date of Burial 2/9 1927

20 UNDERTAKER Jack Levy

ADDRESS

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18805 — 102 E 18805

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH — CITY OF BALTIMORE. (No.) 3600 Elm Ave St., 13-52 Ward) — REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret E Fairall

(a) RESIDENCE No. 3600 Elm Ave St., Ward (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female — 4 COLOR OR RACE: White — 5 Single, Married, Widowed, or Divorced: (write the word): Widow

5a If married, widowed or divorced (HUSBAND) of (or) WIFE of John B Fairall (deceased)

6 DATE OF BIRTH (month, day, and year) Mar. 22, 1842

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 84 | 10 | 15 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: at Home Dd
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS
10 NAME OF FATHER: Henry Baldwin
11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland
12 MAIDEN NAME OF MOTHER: Clemanta Kean
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: H. M. Davis
(Address) 3600 Elm Ave

15 Filed Feb 8, 1927 — C. HALTON JONES, M. D., Registrar — Per R.E.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 7 1927.

17 I HEREBY CERTIFY, That I attended deceased from Jan 10 1927 to Feb 7 1927.
that I last saw h~~e~~ alive on Feb 7 1927.
and that death occurred, on the date stated above, at 11.0 m.
The CAUSE OF DEATH* was as follows:

Senility

(duration) Indefinite yrs. mos. ds.
CONTRIBUTORY (Secondary) Pulmonary Hypostasis
(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No.
What test confirmed diagnosis? Physical Exam
(Signed) R B Noonan, M. D.
2.8. 1927 (Address) 3643 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| St Marys Hampden | Feb 9 27 |
| 20 UNDERTAKER | ADDRESS |
| H S Marshall | 3539 Fallsroad |

Feb 9 1927

Cor.—1-12-23—M&T—100 Bks.

E 18806 HEALTH DEPARTMENT—CITY OF BALTIMORE E 18806

# CERTIFICATE OF DEATH.

REGISTERED NO. 15-65 170

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Union Protestant Hosp St. (or) WARD)

2-FULL NAME Frank C. Peppler

(a) RESIDENCE NO 3701 Clifton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 3 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | White | Married |

If married, widowed, or divorced HUSBAND of (or) WIFE of Jane Peppler

DATE OF BIRTH (month, day, and year) Oct. 27, 1886

| AGE | Years | Months | Days | If LESS than 1 day, ....hrs. or ....min. |
|---|---|---|---|---|
| | 40 | 3 | 11 10 | |

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer American Can Co. Baltimore Md.

BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Wm. J. Peppler

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Delia Hammerbacher

13 BIRTHPLACE OF MOTHER (city or town) Richmond (State or country) Va

Informant Mrs. Jane Peppler
(Address) 3701 Clifton Ave. Balto. Md.

Filed FEB 9 1927, 192 P.M.

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 7 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry I find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Gun shot Through Head Suicide

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Thos. H. Morrison, M. D. (Coroner.)

Feb 10, 1927 (Address) 1502 Reboldi

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL Feb. 9 1927

20 UNDERTAKER Wm. Tickner & Sons ADDRESS North Ave

ec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18807

## CERTIFICATE OF DEATH.

84

E 18807
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 733 Bradley St. 17-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roland Wilson

(a) RESIDENCE NO. 733 Bradley St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | col | Single |

6 If married, widowed, or divorced HUSBAND of (or) WIFE of —

DATE OF BIRTH (month, day, and year) Oct. 5 1898

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 28 | 4 | 2 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Delivery man

(b) General nature of industry, business, or establishment in which employed (or employer) Florist

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Evans Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Emma Hinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Evans Wilson
(Address) 733 Bradley St

15 FEB 9 1927 H. HAMPTON JONES, M. D., Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1927

17 I HEREBY CERTIFY, That I attended deceased from July 4, 1927, to July 7, 1927

that I last saw h[illegible] alive on July 7, 1927

and that death occurred, on the date stated above, at m

The CAUSE OF DEATH* was as follows:

Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Frank E. Magruder, M. D.

2/7, 1927 (Address) 1018 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL Feb 10 1927

20 UNDERTAKER Daniel Easton

ADDRESS 716 Eutaw

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18808

## CERTIFICATE OF DEATH.

129 ✓

REGISTERED NO. E 18808

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 522 Laurens St. 14-20 Ward)

2-FULL NAME John Morgan

(a) RESIDENCE NO. 522 Laurens St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | colored | married. |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Elizebeth morgan

6 DATE OF BIRTH (month, day, and year) 1870

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 57 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer odd

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town)

(State or country) Amelia co Va

PARENTS

10 NAME OF FATHER May morgan

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Mrs Mary Williams

(Address) 522 Laurens St

15 Filed ..... 19..... Registrar

FEB 9 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 February 6

17 I HEREBY CERTIFY, That I attended deceased from Jan 9, 1927, to Feb 6, 1927, that I last saw h[illegible] alive on Feb 5, 1927, and that death occurred, on the date stated above, at 4301 m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? H McCard, M. D.

(Signed)

Feb 8, 1927 (Address) 2005 Hillen

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn cemetery — Date of Burial Feb 9 1927

20 UNDERTAKER Thomas E. Kelson — ADDRESS 1303 Pressman St

cc.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

18809

## CERTIFICATE OF DEATH.

9 / E 18809

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital ST. 24-33 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Fortman

(a) RESIDENCE NO. 1255 Riverside Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 5 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Female | White | Single |

6 If married, widowed, or divorced HUSBAND of (or) WIFE of —

DATE OF BIRTH (month, day, and year) Aug. 20, 1924

| AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 2 | 5 | 18 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Caspar Fortman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Ella Goodrich

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Casper Fortman

(Address) 1255 Riverside Ave

15 Filed FEB 9 1927 C. H. LAWSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 6, 1927, to Feb 7, 1927, that I last saw her alive on Feb 7, 1927 and that death occurred, on the date stated above, at 9 25 p m.

The CAUSE OF DEATH* was as follows:

Pertussis

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Myron G. Tull, M. D.

2/9, 1927 (Address) Sydenham Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Holy Cross O. A. Co. | 2-9 1927 |
| 19 UNDERTAKER E & B Hahn | ADDRESS 115 E West St |

pec.—6-9-19—H. P. Co.—1000 Eks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

18810

CERTIFICATE OF DEATH.

18810

1-PLACE OF DEATH Franklin Sq. Hospital

CITY OF BALTIMORE: (No. 2077 St.) (Ward) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Buckingham Coolen

(a) RESIDENCE. NO. 1753 N Gross St. WARD. 24

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Frederick Coolen

6 DATE OF BIRTH (month, day, and year) Aug 25 1888

7 AGE — Years: 38 Months: 5 Days: 14 If LESS than 1 day, ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balti Md.

PARENTS

10 NAME OF FATHER Leroy Buckingham.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Margt Buckingham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant James H Coolen (Address) 1753 N Gross St

15 Filed FEB - 9 1927 C. HAMPTON JONES, M. D. Registrar Per

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-8th 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 6th, 1927, to Feb 8th, 1927, that I last saw her alive on Feb 8th, 1927, and that death occurred, on the date stated above, at 6 05 A. m.

The CAUSE OF DEATH* was as follows:

Eclampsia (Acute)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Dalgliesh M. D.

, 19 (Address) Franklin Sq. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: 2-11th 1927

20 UNDERTAKER: E. J. Deeks — ADDRESS: 115 E. West St

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 ✓

E 18811

## CERTIFICATE OF DEATH

E 18811

1-PLACE OF DEATH

REGISTERED NO. 20-69

City of BALTIMORE: (No. 2657 Edmondson Ave St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph H. Swartzman

(a) RESIDENCE NO. 2657 Edmondson Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. — mos. — ds. How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of Charlotte D. Swartzman

6 DATE OF BIRTH (month, day, and year) July 16, 1887

| 7 AGE | Years | Months | Days | IF LESS than 1 day ... hrs. or ... min.. |
|---|---|---|---|---|
| | 39 | 6 | 24 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Collector

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer Hecht Bros Co.

9 BIRTHPLACE (city or town) ...

(State or country) New York

PARENTS

10 NAME OF FATHER Andrew J. Swartzman

11 BIRTHPLACE OF FATHER (City or town) ...

(State or country) Not Known

12 MAIDEN NAME OF MOTHER Margaret Kurtz

13 BIRTHPLACE OF MOTHER (city or town) ...

(State or country) Canada

14 Informant Mrs. Charlotte D. Swartzman

(Address) 2657 Edmondson Ave

15 Filed ... 19 ... Registrar

FEB - 9 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) FEB 8 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 3, 1926 to Feb. 8th 1927

that I last saw h... alive on Feb. 8th 1927

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. 5 mos. 5 da.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) ... yrs. ... mos. 1 da.

18 Where was disease contracted

If not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) Mark J. Hellen, M. D.

, 19 (Address) 3838 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

Date of Burial FEB 10 1927 19

20 UNDERTAKER Geo W Little

ADDRESS 2700 EDMONDSON AVE.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE.

E 18812

## CERTIFICATE OF DEATH.

129 E 18812

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 3036 Barclay St. 12-50 Ward)

2-FULL NAME Alice G. Gibson

(a) RESIDENCE NO. 3036 Barclay St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced (or) WIFE of John Harper Gibson

6 DATE OF BIRTH (month, day, and year) April 13th 1857

| 7 AGE Years | Months | Days | IF LESS than 1 day ...hrs. or ...min. |
|---|---|---|---|
| 69 | 10 | 25 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nothing

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) New York City (State or country)

PARENTS

10 NAME OF FATHER Joseph Lamb

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Alice Cassidy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant Miss Grace Monson

(Address) 3036 Barclay St

15 Filed 9 1927 Registrar R.H.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 8th 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 31st 1927, to Feb 8th 1927, that I last saw h.. alive on Feb 8th 1927, and that death occurred, on the date stated above, at 2.20 P. m.

The CAUSE OF DEATH* was as follows:

Uraemic Coma

Interstitial Nephritis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, Cerebral Hemiplegia

(duration) 2 yrs. 6 mos. 6 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Clinical

What test confirmed diagnosis?

(Signed) J. E. Saunders, M. D.

2/8. 1927 (Address) 719 E. Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Feb 11 1927

20 UNDERTAKER G. H. Little

ADDRESS 2120 Edmondson

Spec. 6-9-19—H. P. Co.—1600 Bks.

E 18813 HEALTH DEPARTMENT—CITY OF BALTIMORE

90

CERTIFICATE OF DEATH.

E 18813

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2095 E. Chapel ST. 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Matuszak.

(a) RESIDENCE. No. 1944 E. Lombard ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | White | Widower |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Matuszak

6 DATE OF BIRTH (month, day, and year) Nov 8 1857

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| 69 | 70 | 2 | 28 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Jos Kotula (Address) 1944 E. Lombard St

15 Filed JUN 9 1927, 19 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 17, 1927, to Feb. 6, 1927, that I last saw him alive on Feb. 6, 1927, and that death occurred, on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis ? Endocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas J. Zeigler, M. D.

2/7, 1927 (Address) 2007 E. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| St Stanislaus Cem | Feb 10 1927 |
| 20 UNDERTAKER | ADDRESS |
| Geo M. Frick & Son | 847 W Lombard |

Spec.—7-17-26—A Co.—200 Bks.

Dr Schlenger 3034 E Baltst

118-001

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

18814

E 18814

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hosp St. 24-33 Ward)

2-FULL NAME Harry R Honey

(a) RESIDENCE NO. 411 Grindal St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Honey

6 DATE OF BIRTH (month, day, and year): May 26 1869

7. AGE: Years 57 Months 8 Days 10 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Odd

(c) Name of employer: self

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Mack Honey

11 BIRTHPLACE OF FATHER (City or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Sarah Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mary Honey

(Address) 411 Grindal St. City

15 Filed ..... 19 .....

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 5, 1927, to Feb 6, 1927,

that I last saw h~~im~~ alive on Feb 6, 1927,

and that death occurred, on the date stated above, at 3.05 P m.

The CAUSE OF DEATH* was as follows:

Generalized peritonitis

Gangrenous sigmoid

(duration) ..... yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Strangulated ~~Ingu~~ inguinal Hernia (duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 2/5/27

Was there an autopsy? No

What test confirmed diagnosis? Clinical data

(Signed) Leo Schlenger, M. D.

. 19 (Address) 3034 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet — Date of Burial: Feb 9 1927

20 UNDERTAKER: W. Cook — ADDRESS: 507 E North Ave.

CERTIFICATE OF DEATH FEB 6 1927

Spec.—12-9-25—A C—200 Bks.

E 18815

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

3/4 E 18815

REGISTERED NO._____

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. 25-75 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Brumwell

(a) RESIDENCE NO. 2 Middle St. Brooklyn Md St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Clara Brumwell

6 DATE OF BIRTH (month, day, and year): March 2 - 1878

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 49 | 11 | 5 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer do

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Maryland

PARENTS

10 NAME OF FATHER Lewis Brumwell

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie —

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Maryland

14 Informant

(Address) Records

15 Filed ..... 19..... Registrar

C. HARRY JONES

2-9-1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 7 1927

17

I HEREBY CERTIFY, That I attended deceased from February 4, 1927, to February 7, 1927, that I last saw him alive on February 6, 1927, and that death occurred, on the date stated above, at 6.45 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis (active)

Myocardial hypertrophy

(duration) ....yrs. 2 mos. ....ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) ....yrs. ....mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? n.a. Date of

Was there an autopsy? yes

What test confirmed diagnosis? general & laboratory

(Signed) R. Troop Smith, M. D.

Feb 7. 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery — Date of Burial 2/10 1927

20 UNDERTAKER: William Cook — ADDRESS 502 E North Ave

ec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18816

## CERTIFICATE OF DEATH.

41

E 18816

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Joseph's Hospital

CITY OF BALTIMORE: (No. 1668 ST.. WARD)

2-FULL NAME James Frank Gray Sr.

(a) RESIDENCE No. 2725 W Lafayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W. | Married |

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Ella

DATE OF BIRTH (month, day, and year) Nov. 26 1857

| AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 42 | 0 | 11 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer John L Gregg

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER James Gray Md

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary E Dunn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Mary E Gray

(Address) 2015 Westwood Ave

Filed FEB 9 1927 H. LESTER REYNOLDS, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/7/ 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 4 1927 to Feb 7 1927, that I last saw h— alive on Feb 7 1927, and that death occurred, on the date stated above, at 8:10 P m.

The CAUSE OF DEATH* was as follows:

Infection Foot following abrasion of a corn left Malleolus

(duration) 15 yrs. mos ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Following abrasion of foot

Did an operation precede death? No Date of Jan 25 27

Was there an autopsy?

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Chesnutt B. Wooten M. D.

19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet

DATE OF BURIAL 2/10 1927

20 UNDERTAKER William Cook

ADDRESS 502 E North Ave

Spec.—1-10-21—M&T—1500 Bks.

E 18817

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18817

## CERTIFICATE OF DEATH.

12-50 129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2818 Guilford Ave. ST., WARD)

2-FULL NAME August Meyers.

(a) RESIDENCE NO. 2818 Guilford Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 88 yrs. 1 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male. | White. | Widower. |

5a If married, widowed, or ~~divorced~~ HUSBAND of (~~or WIFE of~~) Harriet F.C. Meyers.

6 DATE OF BIRTH (month, day, and year) Dec. 22, 1848.

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or min. |
|---|---|---|---|---|
| | 88 | 1 | 14 15 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Lumber dealer.

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Robert E.L. Meyers. (son)

(Address) 2818 Guilford Ave.

15 Filed 2-9 1927 19 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 6th 27.

17 I HEREBY CERTIFY, That I attended deceased from January 18th. 1926 to February 6th. 1927.

that I last saw him alive on February 6th 1927.

and that death occurred, on the date stated above, at 9.30 a. m.

The CAUSE OF DEATH* was as follows:

Organic disease of the Heart and Kidneys.

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Uraemia.

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? ------

Did an operation precede death? No. Date of ----

Was there an autopsy? No.

What test confirmed diagnosis? Clinical diagnosis.

(Signed) Otto M. Reinhardt, M. D.

2/10, 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL Feb 9 1927

20 UNDERTAKER John F. Denny — ADDRESS 713 Light St

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18818

## CERTIFICATE OF DEATH.

31 E 18818

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1507 E Fayette ST. 64 WARD)

2-FULL NAME Arthur Watson

(a) RESIDENCE NO. 1507 E Fayette ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| M | C | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| about 32 | | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brakeman

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N.C.

PARENTS

10 NAME OF FATHER Perry M Watson

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Martha Simmons

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant Edgar Watson (Brother) (Address) 1507 E Fayette St

Filed FEB 9 1927

C. HALTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 30 1927 to Feb 6 1927.

that I last saw him alive on Feb 5 1927,

and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Pleurisy & Effusion

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R F Young M. D.

Feb 7 1927 (Address) 1429 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Guilford N.C

DATE OF BURIAL Feb 9 1927

UNDERTAKER Edward Bryan

ADDRESS 1631 Orleans St

Spec.—12-9-25—A Co.—200 Bks.

E 18819

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 18819

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

REGISTERED NO._____

City of BALTIMORE: (No._____ St., 3-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ollie Hayes

(a) RESIDENCE NO. 1607 E. Lombard St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Negro | ? |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1875

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 52 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?

(State or country)

14 Informant Records

(Address)

15 Filed 2-9-1927 16 [illegible] Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 5 1927

17

I HEREBY CERTIFY, That I attended deceased from February 4, 1927, to February 5, 1927, that I last saw her alive on February 5, 1927, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Chronic Myocarditis & Incipient Pneumonia

(duration) yrs. mos. ? ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical & Laboratory

(Signed) R. Hooper Lovell, M. D.

Feb 6 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery Date of Burial Feb 10 1927

20 UNDERTAKER Edward Boyan ADDRESS 1631 Orleans St

Spec.–7-17-26—A Co.—200 Bks.

18820

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

89 E 18820

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. St Agnes Hospital St. 13-54 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Gasma

(a) RESIDENCE NO. 513 Gold St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | widower |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..hrs. or ..min.. |
|---|---|---|---|---|
| | 72 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) France

(State or country)

PARENTS

10 NAME OF FATHER not given

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Do not Know

12 MAIDEN NAME OF MOTHER Do not Know

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Do not know.

14 Informant Patient Joseph Gasma

(Address) 513 Gold St

15 Filed ... 19 ...

8 - 9 1927 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-7- 1927

17 I HEREBY CERTIFY, That I attended deceased from 2-5, 1927, to 2-7, 1927, that I last saw h[illegible] alive on 2-7, 1927, and that death occurred, on the date stated above, at 10 30 A. m.

The CAUSE OF DEATH* was as follows:

Benign hypertrophy of Prostate

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Angina (Cor.)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clynical

(Signed) [illegible] M. D.

. 19 (Address) [illegible]

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

Date of Burial 2/11- 1927

20 UNDERTAKER Martin Fahey & Sons

ADDRESS [illegible] North Ave

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 18821

## CERTIFICATE OF DEATH.

E 18821

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 814 W Mulberry St. 18-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louella Berger

(a) RESIDENCE NO. 814 W. Mulberry St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 Color or Race: Col'd

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1909

7 AGE: Years 18 | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Va

PARENTS

10 NAME OF FATHER Wm Simons

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unk

12 MAIDEN NAME OF MOTHER Wm Simons

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unk

14 Informant Mary Johnson

(Address) 814 Mulberry

15 Filed FEB 8 1926 HARRY J. JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 8/27 19

17

I HEREBY CERTIFY, That I attended deceased from Feb 5, 19 27, to Feb 8, 19 27,

that I last saw h..... alive on Feb 8, 19 27,

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulm Abscess

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Feb 8/27 H Norment, M. D.

Feb 19 (Address) 934 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — Date of Burial: Feb 11 1927

20 UNDERTAKER: Daniel Easton — ADDRESS 916 Penna Ave

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001 E 13822

## CERTIFICATE OF DEATH.

E 13822 PLACE OF DEATH

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. Johns Hopkins Hospital. St. 5-8 Ward)

2-FULL NAME Baby Feldman

(a) RESIDENCE NO. 95 N Eden St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 8 - 1927

7 AGE: Years ___ Months ___ Days one

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ___

(b) General nature of industry, business, or establishment in which employed (or employer) ___

(c) Name of employer ___

9 BIRTHPLACE (city or town) ___

(State or country) Md.

PARENTS

10 NAME OF FATHER Benjamin Feldman

11 BIRTHPLACE OF FATHER (city or town) ___

(State or country) Md.

12 MAIDEN NAME OF MOTHER Jean Cohen

13 BIRTHPLACE OF MOTHER (city or town) ___

(State or country) Russia

14 Informant C H Peckham

(Address) Johns Hopkins Hospital

15 Filed_____, 19_____ C. HARRON JONES, M.D. Registrar

FEB - 9 1927 By PRK

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 9 19 27

17 I HEREBY CERTIFY, That I attended deceased from Feb. 8, 1927, to Feb. 9, 1927,

that I last saw him alive on Feb. 9, 1927,

and that death occurred, on the date stated above, at 1:15 A.m.

The CAUSE OF DEATH* was as follows:

Prima Immaturity

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) ___

(duration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted

If not at place of death? ___

Did an operation precede death? no Date of ___

Was there an autopsy? no

What test confirmed diagnosis? ___

(Signed) C H Peckham, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Mt Carmel Date of Burial 2/9 1927

20 UNDERTAKER: L Fenneson Bro ADDRESS 147 E Balto St

Spec.—1-10-21—M&T—1500 Bks.

E 18823 HEALTH DEPARTMENT—CITY OF BALTIMORE 161-09 E 18823

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 614 W. Conway ST. 27-30 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Green

(a) RESIDENCE NO. 614 Conway ST., ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Feb 5, 1927

7 AGE — Years: — Months: — Days: 2 If LESS than 1 day, ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED: —

(a) Trade, profession or particular kind of work: ..... (illegible)

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Balto, Md

PARENTS

10 NAME OF FATHER: Lewis Green

11 BIRTHPLACE OF FATHER (city or town) (State or country): E C

12 MAIDEN NAME OF MOTHER: Virgie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): S. C.

14 Informant: Virgie Green

(Address): 614 W. Conway

15 Filed: - 9 1927 C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 7th 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 5th, 1927, to Feb 7th, 1927, that I last saw h[illegible] alive on Feb 6th, 1927, and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth

8 months

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Harriett Brown, M. D.

1927 (Address) 1916 Pennsylvania

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Cemetery

DATE OF BURIAL: 2, 9 1927

20 UNDERTAKER: Mrs Geo H Hooper

ADDRESS 406 W Conway

ec.—1-12-23—M&T—500 Bks.

E 18824 HEALTH DEPARTMENT—CITY OF BALTIMORE E 18824

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2621 Frederick Ave. ST. 10-69 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Matilda Linsenmeyer

(a) RESIDENCE NO. 2621 Frederick Ave. ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Jan. 8, 1874

| AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 53 | 1 | XXX | |

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Operator

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Oppenheimer & Obendorf

8 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John Linsenmeyer

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Smith

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs. Pauline Gehringer
(Address) 2621 Frederick Avenue

15 FEB 9 1927 19 Hamden Jones, M. D.
(Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 8 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 - 1927 to Feb 8 1927; that I last saw her alive on Feb 8 1927 and that death occurred, on the date stated above, at 5.45 a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
Encephalitis
Hypostatic Congestion of Brain.

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Nathan R. Kleh, M. D.

Feb. 8, 1927 (Address) 2151 Wilkens Avenue

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Feb. 11, 27

20 UNDERTAKER Joseph B. Cook

ADDRESS 1003 W. Balto St.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18825 | CERTIFICATE OF DEATH.. | 124 | E 18825

REGISTERED NO. .....

1-PLACE OF DEATH Maryland General Hospital

CITY OF BALTIMORE: (NO. ..... ST., 15 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Robert Franklin Maddox

(a) RESIDENCE NO. 4001 Bonner Rd ST., ..... WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 72 yrs. 4 mos. 13 ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr Robert L. Maddox

6 DATE OF BIRTH (month, day, and year) Sept 26 1854

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 72 | 4 | 13 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 004

(b) General nature of industry, business, or establishment in which employed (or employer) Insurance etc

(c) Name of employer U. S. F. & G. Co.

9 BIRTHPLACE (city or town) Somerset County (State or country) Md.

PARENTS

10 NAME OF FATHER Danniell H Maddox

11 BIRTHPLACE OF FATHER (city or town) (State or country) Somerset County Md

12 MAIDEN NAME OF MOTHER Susan V. Ballard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Somerset County Md

14 Informant (Address) Hooper Rooms.

15 Filed 9-1927 C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 8 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 1st, 1927, to Feb 8, 1927, that I last saw h[illegible] alive on Feb 8, 1927, and that death occurred, on the date stated above, at 9 20 a m.

The CAUSE OF DEATH* was as follows:

Cholecystitis

(duration) 15 yrs. mos ds.

CONTRIBUTORY (Secondary) Peritonitis (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 2-3-26

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno A Dempsey Jr M. D.

, 19 (Address) The Jun Hooper

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL Feb 10 1927

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 108 W. NORTH AVE.

ec.—1-12-23—M&T—500 Bks.

E 18826

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18826

## CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 901 Roland Av ST. (WARD) 27-53

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie Marion Horner

(a) RESIDENCE NO. 901 Roland Av ST., WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 1 mos. 10 ds. How long in U. S., if of foreign birth? 58 yrs. 1 mos. 10 ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of George A. Horner

DATE OF BIRTH (month, day and year) Dec-30-1868

| AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 58 | 1 | 10 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Robt. J. Grun

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Balto. Md.

12 MAIDEN NAME OF MOTHER: Sarah Frush

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Co. Maryland.

14 Informant: John A. Horner (Son)

(Address) 901 Roland Ave.

15 Filed: 3 1927 C. HALLSON JONES, M. D. Registrar

Rec'd.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-7 19-7

17 I HEREBY CERTIFY, That I attended deceased from -, 19-7, to 2-7, 19-7,

that I last saw her alive on 2-8, 19-7,

and that death occurred, on the date stated above, at 7:30 P m.

The CAUSE OF DEATH* was as follows:

ARTERIOSCLEROSIS - HYPERTENSION - CHR. NEPHRITIS

(duration) -7 yrs. - mos - ds.

CONTRIBUTORY (Secondary) TERTIARY HEMORRHAGE

(duration) - yrs. - mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John A. Young, M. D.

, 19 (Address) 1109 St. Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Feb 10 1927

20 UNDERTAKER: STEWART & HOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS: 108 W. NORTH AVE.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 18827

159-002

E 18827

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital 13-54 St. (Ward)

2-FULL NAME Baby Boy Schneider

(a) RESIDENCE NO. 811 Pennington Ave St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 0 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | — |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 2-7-27

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | | | 2 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto City Md

(State or country)

PARENTS

10 NAME OF FATHER Earl Schneider

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Rose Goldberg

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Md

14 Informant (Address) Hospital

Filed 9 1927, 19

C. HAMPSON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

2-9-27

17

I HEREBY CERTIFY, That I attended deceased from 2-7, 1927, to 2-9, 1927, that I last saw h[im] alive on 2-9, 1927, and that death occurred, on the date stated above, at 12 20 P. m.

The CAUSE OF DEATH* was as follows:

Premature

Atelectasis

Congenital Cardiac Disease

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinically

(Signed) Harry Weintraub, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Rehrersburg Berks Co Pa 2/1 1927

20 UNDERTAKER ADDRESS

Jack Lewis 1439 E Balto St

Cor.—12-9-25—A Co.—200 Bks.

(Purcell)

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18828

## CERTIFICATE OF DEATH.

185 E 18828

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 419 Pine St St., 17-25 Ward)

2-FULL NAME Norman Purcell

(a) RESIDENCE NO. Hanford Road St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Helen Purcell

6 DATE OF BIRTH (month, day, and year) unknown

| 7 AGE. | Years | Months | Days | IF LESS than 1 day..... hrs. or.....min. |
|---|---|---|---|---|
| About 49 | | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plasterer

(b) General nature of industry, business, or establishment in which employed (or employer) Unemployed

(c) Name of employer

9 BIRTHPLACE (city or town) Portsmouth

(State or country) Virginia

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Not known

14 Informant Clarence Purcell

(Address) Belair Rd

9 1927 19 REGISTRAR JUN 1 1927

Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/7 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Accidental Fall, down Cellar Steps at 419 Pine St

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fracture Base of Skull

(duration) yrs. mos. ds.

(Signed) Harris Wisler M. D.

(Coroner)

, 19 27 (Address) 3325 Pall Mall

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Center Cemetery Co. | Jun 1 19 |

20 UNDERTAKER Homberger & Sons ADDRESS Reisterstown

Spec. 6-9-19—H. P. Co.—1000 Bks.

18829

# HEALTH DEPARTMENT—CITY OF BALTIMORE

18829

## CERTIFICATE OF DEATH.

143-003

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No 1403 Washington Boulevard (If not in hospital or institution)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Etta L. Wagner

(a) RESIDENCE No 1403 Washington Blvd WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life - mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Oliver J. Wagner

6 DATE OF BIRTH (month, day, and year) Dec 14 - 1882

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 44 | 1 | 25 24 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Wm. P. Hood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Mary S. Vick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Oliver J. Wagner

(Address) 1403 Washington Blvd.

15 FEB 9 1927 C. HAMPSON JONES, M. D. Registrar

Per AKH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 8th 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec. 25, 1926. to Feb 8, 1927.

that I last saw her alive on Feb. 8th 1927.

and that death occurred, on the date stated above, at 6.10 P. M.

The CAUSE OF DEATH* was as follows:

Heart disease - Cardiac Dilatation

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Pregnancy & Confinement

(duration) yrs. 2 mos. ds.

18 Where was disease contracted — if not at place of death? Place of death.

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical Symptoms

(Signed) Wm. M. Pannebaker M. D.

1927 (Address) 2740 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemy

DATE OF BURIAL Feb 11 1927

20 UNDERTAKER Jos Joerdens Son

ADDRESS 2078 Bdwy

Spec.—1-10-21—M&T—1500 Bks.

E 18830 HEALTH DEPARTMENT—CITY OF BALTIMORE E 18830

CERTIFICATE OF DEATH. 90

REGISTERED NO. 13-54

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2509 Woodbrook Ave., ST. WARD)

2-FULL NAME George W. Brown

(a) RESIDENCE NO. 2509 Woodbrook Ave., ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Jane Brown

6 DATE OF BIRTH (month, day, and year) July 4, 1849

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 77 | 7 | 4 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Winchester Va.

PARENTS

10 NAME OF FATHER William J. Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Anna Diffendaffer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs Carrie Mae Thompson (Address) 2509 Woodbrook Ave.

15 FEB 9 1927 19 Per C. HALPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 8 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 7, 1927, to Feb 7, 1927, that I last saw h[illegible]e on Feb 7, 1927, and that death occurred, on the date stated above, at 1.20 A.m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion 2 ds.
(duration) yrs. mos.

CONTRIBUTORY (Secondary) Fibrulus Heart
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Heart Beat.

(Signed) Raymond Sylvanus Gathbund M. D.

(Address) Feb 8 1927

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL Feb. 10 1927

20 UNDERTAKER Nelson E. Stiles

ADDRESS 731 Madison Westport

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18831 E 18831

CERTIFICATE OF DEATH.

REGISTERED NO. 2753

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 901 Lane Nr Charles St) (Ward) 27

2-FULL NAME Rev. Richard Paine Kane.

(a) RESIDENCE NO. St Vincents Male Orphan Asylum

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6/7/1875

7 AGE — Years: 51 52 | Months: 8 | Days: 1 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Priest

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Newark

(State or country) N. J.

PARENTS

10 NAME OF FATHER John Kane

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Jane

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Miss M. Kane

(Address) Newark N. J.

9 1927 C. HALPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 8. 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 1927, to Feb. 8 1927, that I last saw him alive on Feb. 6 1927, and that death occurred, on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris 5 minutes (duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

indefinite (duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E H Hayward, M. D.

2/9, 1927 (Address) 225 W Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Newark N. J. Date of Burial: 2/10/1927

20 UNDERTAKER: J Foley & Sons ADDRESS: 1318 Light

Spec.—12-9-25—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18832

101-00.1

E 18832

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St. 7-4 Ward)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Brown

(a) RESIDENCE NO. 2044 Eastern Ave St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widowed |

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1865

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 62 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Virginia

PARENTS

10 NAME OF FATHER Wm Nesbit

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Annie Brooks

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Ireland

14 BALTIMORE CITY HOSPITALS

(Address) [redacted]

C. HAMPSON JONES, M. D.

15 Filed Feb 9 1927 Per _____ Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 8 1927

17 I HEREBY CERTIFY, That I attended deceased from February 5, 1927, to February 8, 1927, that I last saw her alive on February 7, 1927, and that death occurred, on the date stated above, at 12-20 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Empyema

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY Myocardial failure

(Secondary)

(duration) ....yrs. ....mos. 1 ds.

18 Where was disease contracted

If not at place of death? _____

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis? general & laboratory

(Signed) P. Hooper per Smith, M. D.

Feb 9 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Date of Burial Feb 9 1927

20 UNDERTAKER Mendell J. Lippel ADDRESS 300 Eastern Ave

Spec.—12-9-25—A Co.—200 Bks.

9660

E 18833

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

45 E 18833

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) HOPKINS HOSPITAL St. 3-4 (Ward)

2-FULL NAME Rufus Randolph

(a) RESIDENCE NO. 419 S. Spring St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | Col | single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 18 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None -

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Va -

PARENTS

10 NAME OF FATHER ? Randolph -

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va -

12 MAIDEN NAME OF MOTHER Viola -

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va -

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed C. HAMPSON JONES, M. D.

FEB 9 1927 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927

Feb. 7

17

I HEREBY CERTIFY, That I attended deceased from Feb 6, 1927 to Feb 7, 1927, that I last saw h[illegible] alive on Feb. 7, 1927, and that death occurred, on the date stated above, at 3:50 a. m.

The CAUSE OF DEATH* was as follows:

Retroperitoneal Sarcoma.

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? ~~None~~ Home

Did an operation precede death? yes Date of 1-17-27

Was there an autopsy? yes.

What test confirmed diagnosis? Autopsy

(Signed) J. Warfield Mc Farlan M. D.

, 19 (Address) Hyde

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Hope. Date of Burial 2/10 1927.

20 UNDERTAKER Wendell & Slippel ADDRESS 300 S Eden

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

18834 E 18834

## CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2504 Sycamore St. (Ward) 69

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Green

(a) RESIDENCE NO. 2504 Sycamore St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 8 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James E. Green

6 DATE OF BIRTH (month, day, and year): May 15 1859

7 AGE: Years 68 Months 8 Days 24 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: John Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Margaret Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant: Adelaide Barnett

(Address) 2504 Sycamore St

15 Filed 9 1927 C. HAMPSON JONES, Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): February 8th 1927

17 I HEREBY CERTIFY, That I attended deceased from March 10 1925 to 8 Feb 1927.

that I last saw her alive on 8 Feb 1927.

and that death occurred, on the date stated above, at 2.00 P m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary): Cerebral Hemorrhage

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Pneumonia.

(Signed) J Vance Hooper M. D.

, 19 (Address) 2565 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Johns Cemetery — DATE OF BURIAL: Feb 10th 1927

20 UNDERTAKER: H. O. Wisgert — ADDRESS: 850 W Baltimore St

Spec.—12-9-25—A Co.—200 Blks.

E 18835

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 18835
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1523 Jefferson St. 6-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabelle Stewart Henry

(a) RESIDENCE NO. 1523 Jefferson St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | C | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alfred Henry

6 DATE OF BIRTH (month, day, and year) 1-8-1856

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 57 | 10 | 29 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeping

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Samuel Stewart

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Md

12 MAIDEN NAME OF MOTHER Mary E. Matthews

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Md

14 Informant Bessie Stewart

(Address) 415 North St

Filed FEB 10 1927 E. HAMPTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-7-1927

17

I HEREBY CERTIFY, That I attended deceased from Feb 2, 1927, to Feb 7, 1927, that I last saw h[illegible] alive on Feb 6, 1927, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Cardio - Renal Chronic

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Marcellus E Foore, M. D.

, 19 (Address) 1475 N Carey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Laurel Cemetery 2-10 1927

20 UNDERTAKER — ADDRESS

Mrs Chas E. Bailey 1421 Jefferson St

Cor.—12-9-25—A Co.—200 Bks.

E 18836

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

100-001 ✓ E 18836

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 1812 E. Eager St St., 7-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Doris Dutton

(a) RESIDENCE NO. 1812 E. Eager St St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | col | single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 14/1926

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | | 2 | 25 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work unfant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md

PARENTS

10 NAME OF FATHER Rpland Dutton

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Mabel Lean

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Mabel Dutton

(Address) 1812 E. Eager St

Filed 2 10 1927 C. HAMPSON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 Feb 8/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Collins M. D.

(Coroner)

2/10/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel cemetery Date of Burial Feb 10 19 27

20 UNDERTAKER Edward Bryan ADDRESS 1051 orleans st

Spec.—12-9-25—2 Co.—200 Bks.

1927

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18837

## CERTIFICATE OF DEATH.

× 58-001

E 18837.

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Maude Moore alias

(a) RESIDENCE NO. apartado 2049 Havana Cuba St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): married -

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George Harding Moore

6 DATE OF BIRTH (month, day, and year): July 29 1889

7 AGE: Years 37 (37) Months 6 Days 10 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: H W

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Winnebago

(State or country): Minn -

PARENTS

10 NAME OF FATHER: Harvey Green

11 BIRTHPLACE OF FATHER (city or town)

(State or country): ?

12 MAIDEN NAME OF MOTHER: Adelaide Chaffee

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Mich -

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed C. HAMPSON JONES, M. D. Registrar

FEB 10 1927

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 Feb 9

17 I HEREBY CERTIFY, That I attended deceased from Jan 13 1927, to Feb 9 1927, that I last saw h.. alive on Feb 9 1927, and that death occurred, on the date stated above, at 4 10 m.

The CAUSE OF DEATH* was as follows:

Pernicious Anaemia

(duration) yrs. 8 (History) mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Cuba

Did an operation precede death? no Date of

Was there an autopsy? yes.

What test confirmed diagnosis? Laboratory

(Signed) W. Lindsay Kniffen, M. D.

2/9 1927 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Havana Cuba

Date of Burial: Feby 11 1927

20 UNDERTAKER: Chas. G. Black

ADDRESS: 742 W. Pratt St

ec.—1-12-23—M&T—500 Blks.

Vacek.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18838 — CERTIFICATE OF DEATH. — X113 E 18838

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 508 N Durham ST. 7-13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Vacek

(a) RESIDENCE NO. Severn Md ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Infant

If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

DATE OF BIRTH (month, day, and year): Dec 16

| AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | | 2 | 7 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Severn Md

PARENTS

10 NAME OF FATHER: James Vacek

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balt Md

12 MAIDEN NAME OF MOTHER: Emma Broth

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltr

14 Informant: Emma Vacek (Address) 508 N Durham St

15 Filed FEB 10 1927 C. HILTON JONES, M. D. Registrar Per R.K.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 9 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 7, 1927 to Feb 9, 1927.

that I last saw him alive on Feb 9, 1927

and that death occurred, on the date stated above, at 7 P m

The CAUSE OF DEATH* was as follows:

Illeo Colitis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary): Cardiac Paralysis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Rypacek M. D.

Feb 9, 1927 (Address) 8 E Mt Vernon Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Feb 10 1927

20 UNDERTAKER: Frank Evans Son — ADDRESS: 900 Eastern Ave

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 18839

## CERTIFICATE OF DEATH.

E 18839

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1155 E Lombard St. 3-5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Aurelia Dacre

(a) RESIDENCE NO. 1155 E. Lombard St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. 4 mos. 21 ds. How long in U. S., if of foreign birth? 8 yrs. 4 mos. 21 ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 17/18

7 AGE: Years 8 | Months 4 | Days 21 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto md.

PARENTS

10 NAME OF FATHER Petro Dacre

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Italy

12 MAIDEN NAME OF MOTHER Marie Pardo

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Italy

14 Informant (Petro Dacre)

(Address) 1155 E Lombard st

15 Filed 3 10 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Feb 8 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb 1st 1927, to Feb 8th 1927, that I last saw h.. alive on Feb 8th 1927, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ....yrs. ....mos. 8 ds.

CONTRIBUTORY (Secondary) acute dilatation of heart

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) T. F. Jenkins, M. D.

2/9, 1927 (Address) 1192 N. milton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — Date of Burial 2/10, 1927

20 UNDERTAKER: Sol Simpson & Bro — ADDRESS 1127 E Balto st

ec.—1-12-23—M&T—500 Blks.

E 18840 HEALTH DEPARTMENT—CITY OF BALTIMORE

46 E 18840

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1715 Appleton St. 15-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Freida Bass

(a) RESIDENCE NO. 1715 Appleton St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | w | widow |

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Abraham Bass

DATE OF BIRTH (month, day, and year) [illegible]

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 70 | — | — | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

PARENTS

14 Informant Lib Bass

(Address) Lubeck 20

15 Filed [illegible] 1927 . 19 [illegible] Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-9 19 27

17 I HEREBY CERTIFY, That I attended deceased from Oct-15, 1927, to Feb-9, 1927,

that I last saw her alive on Feb-9, 1927

and that death occurred, on the date stated above, at 2 m

The CAUSE OF DEATH* was as follows:

Carcinoma - (ovarian papillary)

General Metastasis about 6-8 months

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of Jan-2-27

Was there an autopsy? no

What test confirmed diagnosis? Laboratory

(Signed) Herman Seidel, M. D.

, 19 (Address) 2404 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Hebrew Rest

DATE OF BURIAL 2-10 19 27

20 UNDERTAKER Jack Louis

ADDRESS [illegible]

ec.—1-12-23—M&T—500 Blks.

18841 HEALTH DEPARTMENT—CITY OF BALTIMORE 129 E 18841

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3614 Springdale Ave ST., 95-61 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harris Cohen

(a) RESIDENCE NO. 3614 Springdale ave ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX M | 4 COLOR OR RACE white | 5 Single, Married, Widowed, or Divorced, (write the word) widower

If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie Cohen.

DATE OF BIRTH (month, day, and year) unknown

| AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 57 | — | — | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Louis Cohen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Fanton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant D. Cohen

(Address) 3614 Springdale Ave

Filed 2 10, 1927 C. HARRY JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/9 1927

17 I HEREBY CERTIFY, That I attended deceased from June, 1926, to Feb 9, 1927, that I last saw h[illegible] alive on Feb 9, 1927 and that death occurred, on the date stated above, at 730 P M

The CAUSE OF DEATH* was as follows:

Chronic diffuse nephritis

(duration) 5 yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Jack Cohen, M. D.

2/9, 1927 (Address) 223 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mesrim Rm

DATE OF BURIAL 2/10, 1927

20 UNDERTAKER Jack Levis

ADDRESS 1439 E Baltimore

ec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18842

## CERTIFICATE OF DEATH.

90 E 18842

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1733 E. Baltimore St. (WARD) 6-4

2-FULL NAME Yetta Kessel

(a) RESIDENCE NO. 1733 E Baltimore St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | W | Married |

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Morris Kessel

DATE OF BIRTH (month, day, and year) Unknown

| AGE | Years | Months | Days | If LESS than 1 day, hrs or min |
|---|---|---|---|---|
| | 52 | — | — | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Chaim Kroft

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Leeda

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

PARENTS

14 Informant Jack Lewis

(Address) 1439 Eutaw St

15 Filed FEB 10 1927 [illegible] Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/9 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1927, to Feb 9, 1927.

That I last saw h[illegible] alive on Feb 9, 1927

and that death occurred, on the date stated above, at 1 P m

The CAUSE OF DEATH* was as follows:

arterio-sclerosis - myocarditis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Angina pectoris

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of /

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) I Frederick Lentz, M. D.

2-9, 1927 (Address) Temple Gardens

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Hebrew Friendship | 2/10 1927 |
| 20 UNDERTAKER | ADDRESS |
| Jack Lewis | 1439 Eutaw St |

Spec—12-23-21—E.B.R.S.—400 Blks. Examination — 2429 Fait Ave

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18843 — CERTIFICATE OF DEATH. — 129 E 13843

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 2005 Clifton Ave St. 15-68 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Hudson

(a) Residence No. 2005 Clifton Ave St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3-SEX: F | 4-COLOR OR RACE: W | 5-Single, Married, Widowed, or Divorced. (Write the word.): Married

5a-If married, widowed, or divorced. HUSBAND of (or) WIFE of: Robert H Hudson

6-DATE OF BIRTH (month, day and year): Sept 18, 1882

7-AGE: 44 yrs. 9 mos. 21 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Ireland

PARENTS.
10-NAME OF FATHER: Unknown
11-BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland
12-MAIDEN NAME OF MOTHER: Unknown
13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14-Informant: Robert H. Hudson
(Address) 2005 Clifton Ave

FEB 10 1927 Registered. Harrison Jones M.D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH (month, day and year): Feb 9. 1927

17-I HEREBY CERTIFY, That I attended deceased from July 20, 19 26 to Feb. 9 1927, that I last saw h alive on Feb 9 19 27, and that death occurred, on the date stated above at 220 m. The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis
(Duration) a 7 years ds.
CONTRIBUTORY (Secondary) myocarditis
(Duration) a 6 mos. ds.

18-Where was disease contracted if not at place of death? —
Did an operation precede death? — Date of
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) Francis Jamieson M. D.
2/9/27 1927 (Address) 2431 Fait Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: Feb 11, 1927

20-UNDERTAKER: Wm Cole & Son — ADDRESS

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18844

## CERTIFICATE OF DEATH.

E 18844

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home & Infirmary Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Elizabeth Albaugh

(a) RESIDENCE NO. 4802 Augusta Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | W | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Albaugh

6 DATE OF BIRTH (month, day, and year) June 4, 1875

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 51 | 8 | 5 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto Md

PARENTS

10 NAME OF FATHER George T Evans

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto Md

12 MAIDEN NAME OF MOTHER Anna Magigan

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto Md

14 Informant Mrs. M. A. Bishop

(Address) 4802 Augusta Ave

15 Filed 19 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

February 9, 1927

17 I HEREBY CERTIFY, That I attended deceased from January 29 1927 to February 9, 1927

that I last saw him alive on February 9, 1927

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia; Myocardial Failure

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Chemistry Exam.

(Signed) Vernon H. Norwood, M. D.

7-29-1927 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

London Park Feb 12 1927

20 UNDERTAKER ADDRESS

Wm. Cook 502 E Hoffman

Cor.—12-9-25—A Co.—200 Bks.

E 18845

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 18845

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital St., 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles L. Whittle (Whittle)

(a) RESIDENCE NO. 1903 N. Castle St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 12/1887

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 39 | 6 | 25 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Meat Packer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Albert Getz

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Thos. H. Whittle

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Susan Russell

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Mrs. Grace Sheetz

(Address) 1903 N. Castle St

15 Filed ..... 19 ..... Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 7/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Failure (Myocarditis)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchial Asthma)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Wallers M. D.

(Coroner)

2/8/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State .....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 ~~PLACE~~ OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery Date of Burial 2/10 1927

20 UNDERTAKER William Cook ADDRESS 502 E North St

Dec.—1-12-23—M&T—500 Blks.

18846

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129 E 18846

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mt Hope Retreat ST. 28-63 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate Barry

(a) RESIDENCE NO. 53 R St N.E. Washington D.C. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

If married, widowed, or divorced HUSBAND of (or) WIFE of Bartholomew Barry

DATE OF BIRTH (month, day, and year) June 11 1863

| AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 63 | 7 | 28 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Tipperary Ireland

PARENTS

10 NAME OF FATHER James Russell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tipperary Ireland

12 MAIDEN NAME OF MOTHER Katherine Ryan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Tipperary Ireland

14 Informant Mt Hope Retreat (Address) Mt Hope Retreat

15 Filed FEB 10 1927, 19 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 9 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 12, 1925, to Feb. 9, 1927, that I last saw h[illegible] alive on Feb. 9, 1927, and that death occurred, on the date stated above, at 5.15 P m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(Cerebral Embolus)

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Chr. Interstitial Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Chemical & Physical

(Signed) Milton P. Hall, M. D.

, 19 (Address) Mt. Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D.C.

DATE OF BURIAL 2/10 1927

20 UNDERTAKER E. J. Fanning, Inc - 1938 Lafayette

ADDRESS

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18847

## CERTIFICATE OF DEATH.

155 E 18847

REGISTERED NO. 13159

1-PLACE OF DEATH

City of RALTIMORE: (No. South Baltimore Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles T. Moreland.

(a) RESIDENCE NO. 2629 Francis St. City Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. 4 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 15 1915:

7 AGE: 11 Years 12 | Months 4 | Days 25 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At school

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) ~~Homeland~~ Balto

(State or country) Maryland

PARENTS

10 NAME OF FATHER William T. Moreland

11 BIRTHPLACE OF FATHER (city or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER ~~Anna Stegerman~~ E. Kitzmiller

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Wm. T. Moreland

(Address) 2629 Francis St.

FEB 10 1927

HAROLD JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 9th 1927.

17 I HEREBY CERTIFY, That I attended deceased from Feb. 4th, 1927, to Feb. 9th, 1927, that I last saw him alive on 9th of Feb., 1927, and that death occurred, on the date stated above, at 8.15 A.m.

The CAUSE OF DEATH* was as follows:

Acute Osteomyelitis

(duration) ...yrs. ...mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death? At Home.

Did an operation precede death? Yes Date of Feb. 3 | 27

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. C. Miller, M. D.

, 19 (Address) 20 South Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem. Date of Burial Feb 12 19 27

20 UNDERTAKER: Wm. Lechner, Jun. ADDRESS Mt. Ave

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18848

## CERTIFICATE OF DEATH

22

E 18848

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1125 Longwood St. 16-67 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Donald Hind Reese

(a) RESIDENCE NO. 1125 Longwood St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 6 mos. 7 ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug. 1, 1924

7 AGE — Years: 2 — Months: 6 — Days: 7 — IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md.

PARENTS

10 NAME OF FATHER: Thomas Reese

11 BIRTHPLACE OF FATHER (City or town): Balto.

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Mabel L. Murphy

13 BIRTHPLACE OF MOTHER (city or town): Balto.

(State or country): Md.

14 Informant: Mr. Thomas E. Reese

(Address) 1125 Longwood St.

15 Filed: FEB 10 1927

C. HAMPSON JONES, M. D. Registrar

Rec'd

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 8 19 27

17 I HEREBY CERTIFY, That I attended deceased from Feb 6, 1927, to Feb 8, 1927, that I last saw him alive on Feb 8, 1927, and that death occurred, on the data stated above, at 2.40 P m.

The CAUSE OF DEATH* was as follows:

Capillary Bronchitis

(duration) yr. mos. 3 ds.

CONTRIBUTORY (Secondary): Influenza Pneumonia

(duration) yrs. 4 mos. ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. G. Hearn, M. D.

1927 (Address) 1701 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem.

Date of Burial: Feb 11, 1927

20 UNDERTAKER: Wm. Fleckner Sons

ADDRESS: North St.

Spec. 1-19-21 M&T 1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

18849 REGISTERED NO. E 18849

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Cambridge Apt ST. 12-49 WARD) 90

2-FULL NAME Mrs. Clementine H. Ulman

(a) RESIDENCE NO. Cambridge Apts. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. — mos. — ds. How long in U. S., if of foreign birth? 76 yrs. — mos. — ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If ~~married~~, widowed, ~~or divorced~~ HUSBAND of (or) ~~WIFE of~~ Alfred J. Ulman

6 DATE OF BIRTH (month, day, and year) March 8, 1843

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| 83 | 84 | 11 | 0 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work NONE

(b) General nature of industry, business, or establishment in which employed (or employer) NONE

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) Paris (State or country) France

10 NAME OF FATHER Abraham Harrisse

11 BIRTHPLACE OF FATHER (city or town) Krakow (State or country) Poland

12 MAIDEN NAME OF MOTHER Nanine Prag

13 BIRTHPLACE OF MOTHER (city or town) Paris (State or country) France

14 Informant Raphael Walter

(Address) 1504 Citizens Nat'l Bank Bldg

15 Filed 0 1927, 19 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 8 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1926, to Feb. 8, 1927.

that I last saw h~~e~~r alive on Feb. 7, 1927.

and that death occurred, on the date stated above, at 10 ~~A~~P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

several hrs.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis Angina Pectoris

(duration) yrs mos. ds. about 1yr.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Julius Friedenwald, M. D.

2/9, 1927 (Address) 1013 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oheb Shalom Cem

UNDERTAKER Henry Wenkens & Sons Co

DATE OF BURIAL Feb 11 1927

ADDRESS Eastwood Pk. Catholic

Cor.—12-9-25—A Co.—200 Bks.

E 18850

# HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002 E 18850

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1709 Ruxton ave St., 15-60 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bessie Sinykain

(a) RESIDENCE NO. 1709 Ruxton ave St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | W | widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Simon Sinykain

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 67 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Russia

14 Informant Jack Louis

(Address) [illegible]

15 Filed 1927 19_____

Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 10, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

arteriosclerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) uremia

(duration) — yrs. mos. ds.

(Signed) D. J. Hennessy M. D.

(Coroner)

1927 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Hermon

Date of Burial 7/10 1927

20 UNDERTAKER Jack Louis

ADDRESS 1429 E Baltimore St

Spec.—12-9-25—A Co.—200 Bks.

E 18851

# HEALTH DEPARTMENT—CITY OF BALTIMORE

111-001

E 18851

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home & Infirmary

City of BALTIMORE: (No. 17-50 St. Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edwin Lee Cronk

(a) RESIDENCE NO. 2301 Barclay St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Virginia Grant

6 DATE OF BIRTH (month, day, and year) June 29th 1867

| 7 AGE Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|
| 59 | 7 | 10 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 66

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Edinburg Ind

(State or country)

PARENTS

10 NAME OF FATHER Paul Erwin Grant

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Edinburg Ind

12 MAIDEN NAME OF MOTHER Anna Ingram

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Edinburg Ind

14 Informant Paul Grant

(Address) 2317 Barclay St

Filed FEB 10 1927 C. Hall Williams M.D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-9-27 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 4/27, 1927, to Feb 9th, 1927, that I last saw h[illegible] alive on Feb 9th, 1927, and that death occurred, on the date stated above, at 2:10 A m.

The CAUSE OF DEATH* was as follows:

Myocardial Failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Perforated Gastric Ulcer with generalized peritonitis

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? — (Edgewood)

Did an operation precede death? Yes Date of Feb 6/27

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) R Clark Grove, M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Woodlawn Date of Burial Feb 13th 1927

20 UNDERTAKER Frank V Fletcher ADDRESS 2918 E Baltimore

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 18852

E 18852

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1533 Hanover St. 23-27 Ward)

2-FULL NAME Margaret A. Frazier.

(a) RESIDENCE NO. 1533 Hanover St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female.

4 Color or Race: White.

5 Single, Married, Widowed, or Divorced, (write the word): Infant.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept, 14, 1923.

7 AGE: Years — Months 4, — Days 25. — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant.

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER: James V. Frazier.

11 BIRTHPLACE OF FATHER (city or town): Balto. Md.

(State or country)

12 MAIDEN NAME OF MOTHER: Mary t M. Haslup.

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Balto. Md.

14 Informant: James V. Frazier, (Father).

(Address) 1533 Hanover Street

Filed FEB 10 1927 C. HALSEY JONES, M. D.

By R.K. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 9 1927 - 19 IRK

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1927, to Feb 9, 1927, that I last saw h. alive on Feb 9, 1927, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Acute Broncho Pneumonia

(Primary)

(duration) yrs. mos. 7 ds.

CONTRIBUTORY Convulsions

(Secondary)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R.K. Campbell, M. D.

Feb 10 1927 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem. Date of Burial Feb. 11 1927

UNDERTAKER: E. Edward Evans ADDRESS: 358 Fab Ave

Spec.–7-17-26—A Co.—200 Bks.

Leakin

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 18853

## CERTIFICATE OF DEATH

E 18853

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 602 Linnard St. 16-67 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph M. Leakin

(a) RESIDENCE NO. 602 Linnard St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ida M Leakin

6 DATE OF BIRTH (month, day, and year): June 14, 1875

7 AGE: Years 51 Months 7 Days 24 25

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Bridge Inspector

(b) General nature of industry, business, or establishment in which employed (or employer): B & O R R

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md

PARENTS

10 NAME OF FATHER: Andrew J Leakin

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Ill.

12 MAIDEN NAME OF MOTHER: Agnes A Brown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Ill.

14 Informant: Ida M Leakin

(Address): 602 Linnard St

15 Filed 2/10 1927 C. HAMPSON JONES M.D. Registrar

Filed RK

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 8 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov. 2 1926 to Feb. 8 1927 that I last saw h in alive on 2/8 1927 and that death occurred, on the date stated above, at 5.45 P m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Pulmonary Abscess

(duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death? 602 Linnard St.

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Blood Smear & X-Ray

(Signed) Jack. H. Hodges M. D.

2/9 1927 (Address) 6 E. Gladrich

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Olivet

Date of Burial: Feb 10 1927

20 UNDERTAKER: George J Smith

ADDRESS 1532 Hollins

Spec.—1-10-21 M&T 1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

12E 13854

E 13854

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 132 Rosalie Ave. ST., 27-43 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Preston Muth

(a) RESIDENCE NO. 132 Rosalie Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, Divorced (write the word): ~~Married~~ single

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Ethel C. Muth

6 DATE OF BIRTH (month, day, and year) Jan. 29, 1892

7 AGE: Years 35 | Months 0 | Days 10 | If LESS than 1 day, ... hrs or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Printer

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: Reese Pub. Co. Balto Md.

063

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Albert S. Muth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md. ?

12 MAIDEN NAME OF MOTHER Anna B. Brooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Ethel C. Muth

(Address) 132 Rosalie Ave.

15 Filed . 19 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 8 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 31, 1927, to Feb. 8, 1927, that I last saw him alive on Feb. 7, 1927, and that death occurred, on the date stated above, at 6.30 A. m.

The CAUSE OF DEATH* was as follows:

Acute nephritis anuria

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) G. M. Bacon, M. D.

, 19 (Address) Parkville, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. DATE OF BURIAL: Feb 11 1927

20 UNDERTAKER: Zirkler & Zirkler ADDRESS: 1739 E. Eager

Cor.—12-9-25—A Co.—200 Bks.

E 18855

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

101-001

E 18855

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. West Balto Gen H 11-25 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alexander Gretta

(a) RESIDENCE NO. 317 N Franklin St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 21 68

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 58 | 10 | 17 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocery Room

(b) General nature of Industry, business, or establishment in which employed (or employer) Clerk

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Greece

PARENTS

10 NAME OF FATHER Manuel Gretta

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Greece

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Greece

14 Informant Angelo Pope

(Address) 317 N Franklin

Filed FEB 10 1927 J. H. [illegible] JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 8, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) [illegible] yrs. [illegible] mos. 2 ds.

CONTRIBUTORY (Secondary) acc heart trouble

(duration) [illegible] yrs. [illegible] mos. [illegible] ds.

(Signed) J. H. Jones M. D.
(Coroner)

Feb 9 1927 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery Date of Burial Feb 10 1927

20 UNDERTAKER W M Coulson ADDRESS 230 N Green

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18856 ✓ E 18356

## CERTIFICATE OF DEATH

REGISTERED NO. 25-72

1-PLACE OF DEATH

City of BALTIMORE: (No.) St Agnes Hosp. (Street) (Annie C. Keller) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Ann Keller

(a) RESIDENCE NO. Hopewood Rd Woodlawn Md. St. / Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residenre in city or town where death occurred yrs. 1 mos. 13 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph M Keller

6 DATE OF BIRTH (month, day, and year) Aug 10, 1863

| 7 AGE | Years | Months | Days |
|---|---|---|---|
| | 63 yrs. | 5 | 29 |

IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va.

(State or country)

PARENTS

10 NAME OF FATHER John Shipe

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Rebecca Foster

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Robert A. Groves

(Address) Mt Lond Md

Filed ... 19 ... Harrison Jones, M. D.

Registrar

By RM

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

2-9-1927

17 I HEREBY CERTIFY, That I attended deceased from Dec. 28, 1926, to Feb. 9, 1927.

That I last saw her alive on Feb. 9, 1927.

And that death occurred, on the date stated above, at 9 25 p. m.

The CAUSE OF DEATH* was as follows:

Fracture of neck of left femur - closed.

Fell on ice

(duration) yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos 7 ds.

Where was disease contracted

If not at place of death?

Did an operation precede death? no Data of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical.

(Signed) A J Knapp, M. D.

2-9-, 1927. (Address) Saint Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

Thos. B. Horton M.D. Coroner

19 PLACE OF BURIAL, CREMATION OR REMOVAL Front Royal Va

Date of Burial Feb 11 1927

20 UNDERTAKER Wm Cook

ADDRESS 532 E North Ave

Spec. 1-10-21 M&T 1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18857

18857

CERTIFICATE OF DEATH.

38

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 18-26 ST. WARD)

2-FULL NAME August Penhoobe

(a) RESIDENCE NO. 1107 Pine ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Blk

5 Single, Married, Widowed, or Divorced, (write the word): Separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Catherine

6 DATE OF BIRTH (month, day, and year): 1888

7 AGE: 39 Years 38 Months Days If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Ephriam Penhoobe

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Carrie Chase

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Baltimore City Hospitals

15 0 1927 C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 9. 1927

17 I HEREBY CERTIFY, That I attended deceased from June 19, 1925 to Feb. 9, 1927.

that I last saw him alive on Feb. 9, 1927

and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

General Paralysis (of the Insane)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Senile Dementia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Uniontown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical & Serological

(Signed) Wm. F. Mount M. D.

, 19 (Address) Baltimore City Hospitals P

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Auburn Cem.

DATE OF BURIAL: 2/12 1927

UNDERTAKER: Daniel Coston

ADDRESS: 916 Pa. Ave.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18858

## CERTIFICATE OF DEATH.

11 E 18858

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hospital ST. 9-17 WARD)

2-FULL NAME James Bucy

(a) RESIDENCE NO. 14 Linden Ave. ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) 1906

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 21 | | | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

Filed 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/5 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 21, 1927, to Feb. 5, 1927,

that I last saw him alive on Feb. 5, 1927,

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Appendicitis

Lobar Pneumonia right side

Pleurisy with effusion (left side)

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) Embolism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan 21, 1927

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Clement R. Monroe, M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

JOHNS HOPKINS HOSPITAL FEB

THE MORGUE

Spec.—12-9-25—A Co.—200 Bks.

199405

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18859

1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

56 E 18859

REGISTERED NO.

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 4-6 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME John Evans (Children Visitor)

(a) RESIDENCE NO. 31 S. Calvert St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: Black

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 9 1926

7 AGE: Years — Months 10 Days 17 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph C. Waters

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Marie Evans

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Records

(Address)

15 Filed C. HAMSON JONES, M. D. Registrar

FEB 10 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 6, 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1927, to Feb. 6, 1927, that I last saw h... alive on Feb. 6, 1927, and that death occurred, on the date stated above, at 6 15 m.

The CAUSE OF DEATH* was as follows:

malnutrition

Rickets

(duration) .....yrs. 3 mos. .....ds.

CONTRIBUTORY (Secondary)

Debility

(duration) .....yrs. .....mos. 1 ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thomas B. Cromwell, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

Date of Burial 19

20 UNDERTAKER

ADDRESS

FEB 10 1927

Commissioner of Health

For Sec. L. Burial

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18860

## CERTIFICATE OF DEATH.

101-981

E 18860

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1215 Whetcroft St 16-22 St 16 Ward)

2-FULL NAME Haniel Briscoe

(a) RESIDENCE NO. 1215 Whetcroft St St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Mal | C | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12-25-1885

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 41 | 1 | 1X 13 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer O&D

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) St Mary's Co

(State or country) Md

PARENTS

10 NAME OF FATHER Romulus Briscoe

11 BIRTHPLACE OF FATHER (city or town) St Mary's Co

(State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Curtis

13 BIRTHPLACE OF MOTHER (city or town) St Mary's

(State or country) Md.

14 Informant John Briscoe

(Address) 1456 N. Carey St

Date 1927 C. HAMPSON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-8 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 7, 1927, to Feb 8, 1927, that I last saw h. alive on Feb 8, 1927, and that death occurred, on the date stated above, at 7:45 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY

(Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Marcellus S Jones, M. D.

, 19 (Address) 1456 N Carey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| St Joseph Cemetery St Mary's Co Md | 2/12 1927 |
| **20 UNDERTAKER** | **ADDRESS** |
| Wm J as. H. Dennis for T. E. Nelson | 303 Eastman St |

spec.—1-12-23—M&T—500 Bks.

18861 HEALTH DEPARTMENT—CITY OF BALTIMORE E 18861

CERTIFICATE OF DEATH. Brooklyn

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 501 Washington Ave St., 15 WARD

2-FULL NAME Rachel R Baker

(a) RESIDENCE NO. 501 Washington Ave St., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem'l

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Divorced

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Alfred Baker

6 DATE OF BIRTH (month, day, and year): Oct 3 1879

7 AGE: Years 47 | Months 4 | Days 6 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework at home

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Henry Glenck

11 BIRTHPLACE OF FATHER (city or town) (State or country): Lancaster Pa

12 MAIDEN NAME OF MOTHER: Mary Allen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Mrs Clarence E Baker

(Address) 501 Washington Ave

Filed ... 19 ... C. HARPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 9 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1927 to Feb. 9, 1927.

that I last saw her alive on Feb. 8, 1927

and that death occurred, on the date stated above, at 5-40 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Right Hemiplegia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Walter Wyatt, M. D.

Feb 9, 1927 (Address) 816 Remington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill — DATE OF BURIAL: Feb 12 1927

20 UNDERTAKER: John F Denny — ADDRESS: 715 Lig[illegible] St

Spec.–7-17-26—A Co.—200 Bks.

E 18862

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

129

E 18862

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1020 Seaden hall St. 23-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sandy Syrd

(a) RESIDENCE NO. 102 Seadenhall St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. — mos. / ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah Syrd

6 DATE OF BIRTH (month, day, and year): 1877

7 AGE: Years 50 Months — Days — IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer: Kennedy Iron Co. "Eastern Shore"

9 BIRTHPLACE (city or town): (State or country) Maryland

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (City or town): (State or country)

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town): (State or country)

14 Informant: Edward Syrd

(Address): 1020 Seadenhall

FILED 1927 C. HAMPSON JONES, M. D. Registrar

By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/8 1927

17 I HEREBY CERTIFY, That I attended deceased from 2/7, 1927, to 2/8, 1927, that I last saw h.. alive on 2/8, 1927, and that death occurred, on the date stated above, at 7 40 P. m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) Chr Nephritis

Arteriosclerosis (duration) yrs. unknown mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? None Date of

Was there an autopsy? None

What test confirmed diagnosis? Symptoms

(Signed) David Brumbelow M. D.

2/9, 1927 (Address) 222 W Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery

Date of Burial: Feb 11 1927

20 UNDERTAKER: R. L. Parham

ADDRESS 1216 E. Chase St.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18863

## CERTIFICATE OF DEATH.

90 E 18863

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 229 W. Hamilton St. 73-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Matthews

(a) RESIDENCE NO. 229 W. Hamilton St. Ward

(Usual place of abode) Unknown

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Fe | Col | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Thomas Matthews

6 DATE OF BIRTH (month, day, and year) unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 52 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of indnstry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) unknown

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) unknown

14 Informant Mrs. Gray

(Address) Lee St.

Filed C. HAMPSON JONES, M. D. Registrar

FEB 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 8 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 4, 1927, to Feb 8, 1927, that I last saw h[illegible] alive on Feb 8, 1927, and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) acute Cerebral Dilatation

(duration) yrs. mos. 5 ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) D. Flanagan, M. D.

, 19 (Address) 803 Shaw st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Mt. Auburn Cemetery | Feb 11, 1927 |
| 20 UNDERTAKER | ADDRESS |
| Mrs Tate & V. Williams | 322 N Schroeder st |

pec.—1-12-23—M&T—500 Bks.

E 18864 HEALTH DEPARTMENT—CITY OF BALTIMORE E 18864

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mt Hope Retreat (ST.) 28-63 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lola Osborne

(a) RESIDENCE NO. 1102 E. 21 Wash. D.C. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 6 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 48 Months unknown Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER Francis Osborne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Anna Knott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mt Hope Records

(Address) Mt Hope Retreat

15 FILED 0 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 10 1927.

17 I HEREBY CERTIFY, That I attended deceased from Aug 6, 1926, 1926 to Feb. 10, 1927.

that I last saw h[illegible] alive on Feb. 10, 1927.

and that death occurred, on the date stated above, at 12.15 m.

The CAUSE OF DEATH* was as follows:

(Sub. Hepatic) Carcinoma

unknown (duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Depression Psychosis

(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? yes Date of 1925.

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Milton P. Bell, M. D.

, 19 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wash. D.C.

DATE OF BURIAL 2/10/27

20 UNDERTAKER Timothy F Hanlon

ADDRESS Wash. D.C.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18865

49 E 18865

## CERTIFICATE OF DEATH

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 2508 E. Preston St. 8-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William J. Harrigan

(a) RESIDENCE NO. 2508 E Preston St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6 DATE OF BIRTH (month, day, and year): Jan 29-1880

7 AGE — Years: 46 Months: 10 Days: 9 IF LESS than 1 day ..hrs. or ..min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Confectioner

(b) General nature of industry, business, or establishment in which employed (or employer): Self

(c) Name of employer: Oswego

9 BIRTHPLACE (city or town): NY

(State or country)

PARENTS

10 NAME OF FATHER: Patrick Harrigan

11 BIRTHPLACE OF FATHER (city or town): Ire

(State or country)

12 MAIDEN NAME OF MOTHER: Martha Hurley

13 BIRTHPLACE OF MOTHER (city or town): Ireland

(State or country)

14 Informant: Martha Schlamel

(Address) 2508 E Preston

15 2/10 1927 C. HAMPSON JONES, M. D. Registrar

For ADH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

February 8th 27

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1926 to Feb 8, 1927.

that I last saw h[illegible] alive on Feb 7, 1927.

and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Larynx.

(duration) yrs. 10 mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of Apr. 1926.

Was there an autopsy? No.

What test confirmed diagnosis? Pathological slides.

(Signed) Thos. F. A. Stevens, M. D.

2/8 19 27 (Address) 2875 Hartford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem. — Date of Burial: 2/11 1927

20 UNDERTAKER: J. J. Moran — ADDRESS 3909 E. Baltimore

cc.—1-12-23—M&T—500 Bks.

138866 HEALTH DEPARTMENT—CITY OF BALTIMORE E 18866

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 120 Mosher ST. 14-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Elizabeth Vincent

(a) RESIDENCE NO. 120 Mosher ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

6 If married, widowed, or divorced HUSBAND of (or) WIFE of William P. Vincent

7 DATE OF BIRTH (month, day, and year) Unknown

| AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 61 | -- | -- | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Moses F. Carroll

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret McCormick

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Paul J. Vincent
(Address) 3200 Gwynns Falls Parkway

15 Filed 2-10 1927 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 8th 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 5th, 1927, to Feb 8th, 1927, that I last saw her alive on Feb 8th (6 pm), 1927, and that death occurred, on the date stated above, at 7:55 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Cardiac dilitation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Edwin K. Ballard M. D.

(Address) 1622 N. Royal ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL GOVANS St. Mary's Cemetery

DATE OF BURIAL 2/12 19 27

20 UNDERTAKER Henry W. Mears

ADDRESS Moses F. Calvert

Corr.—12-8-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18867

181-00

E 18867

## CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 612 E Lombard St., 6 Ward)

2-FULL NAME Frank Graf

(a) RESIDENCE NO. 612 E. Lombard St. Ward

(Usual place of abode) Unknown (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1869

7 AGE: Years 5-8 Months Days IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Mrs H. B. Hunt

(Address) 1016 Investment Building Washington D.C.

DEC 1927 C. HAMPSON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 8 27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxia due to Carbon monoxide Gas

(duration) ... yrs. ... mos. ... ds.

CONTRIBITORY (Secondary) Undetermined

(durration) ... yrs. ... mos. ... ds.

(Signed) [illegible] (Coroner) M. D.

Dec 10, 19 27 (Address) 1454 Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cem Date of Burial: Dec 10 1927

20 UNDERTAKER: John McAleer ADDRESS: 1803 Bank St

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18868 182 E 18868

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Foot of Caroline 7-4 St., Ward)

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jos Podraza

(a) RESIDENCE NO. 711 S Bond St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | Widower |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1871

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 56 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer) Huckster

(c) Name of employer

9 BIRTHPLACE (city or town) Poland

(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) Poland

(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) Poland

(State or country)

14 Informant Mrs Catherine Podraza

(Address) 2208 Dillon St

Filed 1927 C. HAMPSON JONES, M. D. Registrar

By

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 8 1927

17 I HEREBY CERTIFY, that I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acc Drowning

Duration yrs. mos. ds.

CONTRIBUTORY (Secondary) As Inquest

(Duration) yrs. mos. ds.

(Signed) J. C. Hodes M. D.

(Coroner)

2/9/27 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus cem Date of Burial Feb 11 1927

20 UNDERTAKER John H Weber ADDRESS 1803 Bank St

Spec.—1-12-23—M&T—500 Blks.

18869

# HEALTH DEPARTMENT—CITY OF BALTIMORE

18869

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH West Balto General Hospital

CITY OF BALTIMORE: (No. Payne and Dukeland ST.) 4-26 (WARD)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherina Harries

(a) RESIDENCE NO. 440 S. Gilmor ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 7 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Dietrich Harries

DATE OF BIRTH (month, day, and year): June 30, 1854

| AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 72 | 7 | 10 | |

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

8 BIRTHPLACE (city or town) (State or country): Balto. Md.

10 NAME OF FATHER: Frederick Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Louisa Trustein

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Caroline A. Parks
(Address) 440 S. Gilmor St

15 1927 C. HAMPSON JONES, M. D. Registrar
Rck

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/9 1927

17 I HEREBY CERTIFY, That I attended deceased from 2/7, 1927 to 2/9, 1927, that I last saw her alive on 2/8, 1927 and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Benjamin Miller, M. D.

Feb 9, 1927 (Address) W. B. G. H.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem — DATE OF BURIAL: Feb 11 1927

20 UNDERTAKER: Mr & Mrs. John W. Tingle — ADDRESS: 84 W Fayette

Spec.—12-9-25—A Co.—200 Blks.

E 18870

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18870

## CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS [redacted] REGISTERED NO. 13-52

City of BALTIMORE: (No. _____ St., _____ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Marsh

(a) RESIDENCE NO. 3629 Chestnut Ave St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1866

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| Given 75? Proven 61 | | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labourer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Baltimore - County

PARENTS

10 NAME OF FATHER Joshua Marsh

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Maryland

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Maryland

14 Informant BALTIMORE CITY HOSPITALS

(Address) Records

Filed FEB 9 1927 C. HAMPSON JONES, M. D.

By _____ Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 8 1927

17

I HEREBY CERTIFY, That I attended deceased from January 31 1927, to February 8, 1927, that I last saw him alive on February 8, 1927, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Emphysema
Cerebral Sclerosis
Chronic Myocarditis 2 yrs Pneumonia
(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Myocardial Failure
(duration) ....yrs. ....mos. 7 ds.

18 Where was disease contracted

If not at place of death? _____

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Laboratory

(Signed) R. Hooper Lamb, M. D.

Feb 9, 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Hampden Date of Burial Feb 11 1927

20 UNDERTAKER Chenoweth Son ADDRESS 3617 Chestnut Ave

Spec.—7-17-26—A Co.—200 Bks.

E 13871

# HEALTH DEPARTMENT—CITY OF BALTIMORE

99-001

E 13871

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 3158 Cedar Ave St. 13-51 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. McQuay.

(a) RESIDENCE NO. 3158 Cedar Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 4, 1925

7 AGE: Years 2 Months Days 5 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Frank J. McQuay

11 BIRTHPLACE OF FATHER (City or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Grace A. Wilson

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Frank J. McQuay.
(Address) 3158 Cedar Ave.

15 Filed FEB 10 1927 G. HAMPSON JONES, M.D. Registrar
Per pcs

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 9, 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 26, 1927, to 2/9, 1927,
that I last saw her alive on 2/9, 1927,
and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchitis, acute

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Pneumonary

(duration) yrs. mos. X ds.

18 Where was disease contracted

If not at place of death? X

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? clinical

(Signed) Florence Z. M. D.

(Address) 2020 N. Charles

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Date of Burial Feb 11 1927

20 UNDERTAKER Chenoweth Son ADDRESS 3417 Chestnut Ave

Cor.—12-9-25—A Co.—200 Bks.

E 18872

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18872

## CERTIFICATE OF DEATH.

161-091

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 76-37 Ward)

2-FULL NAME Sarah Charlotte Bougourd

(a) RESIDENCE NO. 508 S. 14th St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| female | white | single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 6/27

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | | | 2 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md

PARENTS

10 NAME OF FATHER John Bougourd

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Eve Ramuly

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant John Bougourd

(Address) 508 S. 14th St

Filed 0 1927 19 C. HARRISON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 8/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. C. Potter M. D.

(Coroner)

19 2/16/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cemetery Date of Burial 19

20 UNDERTAKER Lilly & Zeller ADDRESS 2038 E. Monument St.

Spec.—12-9-25—A Co.—200 Bks.

# E 18873

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

× 46

# E 18873

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St., 7-9 Ward)

2-FULL NAME Annie C. Slagle

(a) RESIDENCE NO. Lisbon Md St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | married. |

5a If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of Martin W Slagle

6 DATE OF BIRTH (month, day, and year) Aug 28 - 1876

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 50 | 5 | 12 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland.

PARENTS

10 NAME OF FATHER Jeremiah Keck

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Pa.

12 MAIDEN NAME OF MOTHER Barbara Jingling

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland.

14 Informant Martin W. Slagle.

(Address) Lisbon, Howard Co. Md.

0 1927 C. HAMPSON JONES, M. D. Registrar

ORS

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 10, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Feb 2, 1927, to Feb. 10, 1927, that I last saw her alive on Feb 10 —, 1927, and that death occurred, on the date stated above, at 6:55 m.

The CAUSE OF DEATH* was as follows: Carcinoma of Left Ovary Chronic Cardio Valvular disease

Four Mos (duration) yrs (?) mos. ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation & Failure

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 2/5/27.

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) J. Whitridge Williams, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Howard Co., Md. Date of Burial Feby. 13th 1927

Mt Kenrick Cemetery.

20 UNDERTAKER C. M. Waltz ADDRESS Hanfield Md.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18874

E 18874

## CERTIFICATE OF DEATH.

REGISTERED NO. 20-7024

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3149 Stafford St. (ST.) 20-7 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augusta Stellmacher

(a) RESIDENCE NO. 3149 Stafford St., ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Gustave Stellmacher

6 DATE OF BIRTH (month, day, and year) Feb. 27, 1844

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 82 | II | 13 17 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs. Florence Jenkins

(Address) 3147 Stafford St.

Filed 1-11-1927. C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/9 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 16, 1927, to Feb 9, 1927.

that I last saw h alive on 2/8, 1927

and that death occurred, on the date stated above, at 1.30A m.

The CAUSE OF DEATH* was as follows:

arteriosclerosis senilis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cerbral hemorrhage

(duration) yrs. mos. 24 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Fundings

(Signed) Thomas P. Alloy M. D.

, 19 (Address) 3326 Gerkin Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 2/II 1927

20 UNDERTAKER Harry L Witzke

ADDRESS 1531 N. Lombard St

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18875

## CERTIFICATE OF DEATH

15-61 90

E 18875

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2912 Garrison St., 15-61 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hermann D. Engelhardt

(a) RESIDENCE NO. 2912 Garrison Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Erna Engelhardt

6 DATE OF BIRTH (month, day, and year) Sept. 12 1863

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min.. |
|---|---|---|---|---|
| | 63 | 4 | 27 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chemist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Harper & Dohme

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER August Engelhardt

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Minna Base

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs. Erna Engelhardt

(Address) 2912 Garrison Ave.

15 Filed 19 Registrar

FEB 11 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 9 19 27

17 I HEREBY CERTIFY, That I attended deceased from Feb 7 1927, to Feb 9 1927, that I last saw him alive on Feb 9 1927, and that death occurred, on the date stated above, at 10.50 A m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

Arteriosclerosis

(duration) yrs. mos 7 ds.

CONTRIBUTORY Arteriosclerosis

(Secondary)

(duration) 1 yrs. mos ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sign & Symptoms

(Signed) J. D. Chestnut, M. D.

Feb 11 1927 (Address) 500 Academy St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. Date of Burial Feb. 11 1927

20 UNDERTAKER Wm. J. Dickuerdons ADDRESS North Ave

Cor.—12-9-25—A Co.—200 Bks.

E 18876

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 18876

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) On Way to Mercy Hosp (St.) (Ward)

2-FULL NAME Louis T. Street

(a) RESIDENCE NO. 412 N. Regester St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | Col | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 50 yrs | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) O&O

(c) Name of employer

9 BIRTHPLACE (city or town) Va

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Ophila Street

(Address) 412 n Regester st

Filed FEB 11 1927 C. HARRY JAMES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 8 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) yrs. ..... mos. ..... ds.

Feb 9 1927 (Signed) ..... M. D.
(Coroner)

(Address) 1637 Bruce

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Asbury | Feb 11 1927 |

20 UNDERTAKER John W Henderson

ADDRESS 1502 Monument

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18877

## CERTIFICATE OF DEATH.

9 E 18877

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1157 E Eutaw St., 18-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Andrew Supansky

(a) RESIDENCE NO. 1157 E. Eutaw St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Aug 7 1926

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | | 6 | 3 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto City

(State or country)

PARENTS

10 NAME OF FATHER Andrew Supansky

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Eve Ramsky

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto City

14 Informant Andrew Supansky

(Address) 1157 E Eutaw St

15 Filed ..... 19 ..... Registrar

FEB 11 1927

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 10 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Hanging Cough

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) ..... yrs. 4 mos. ..... ds.

(Signed) James McFarlan M. D. (Coroner)

2 11. 1927 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the state.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery Date of Burial Feb 11 1927

20 UNDERTAKER C B Mifflet ADDRESS 850 W Balto St

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18878

## CERTIFICATE OF DEATH

21

REGISTERED NO. E 18878

1-PLACE OF DEATH

City of BALTIMORE: (No. 1238 N Broadway St. 8-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lizon Guy

(a) RESIDENCE NO. 1238 N Broadway St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of: Josephine Guy

6 DATE OF BIRTH (month, day, and year): Jan 9, 1843

7 AGE: Years 84 Months – Days 29 IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Tailor

(b) General natore of industry, bosiness, or establishment in which employed (or employer): 080

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER: James Guy

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Ireland

12 MAIDEN NAME OF MOTHER: Jane Crawford

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Ireland

14 Informant: Josephine Guy

(Address): 1238 N Broadway

15 Filed FEB 1 1927 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 8 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 12, 1927, to Feb 8, 1927.

that I last saw him alive on Feb 8, 1927.

and that death occurred, on the date stated above, at 11 15 P.M.

The CAUSE OF DEATH* was as follows:

Erysipelas

(doration) yrs. 1 mos. 8 ds.

CONTRIBUTORY (Secondary)

Age

(doration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

2010 1927 (Address) 1834 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dallastown Pa

Date of Burial: Feb. 11 1927

20 UNDERTAKER: Clabaugh Bros Inc

ADDRESS: 1422 N. Broadway

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 13879

## CERTIFICATE OF DEATH.

100-001

E 13879

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 552 St. Mary's St. 17-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Payne

(a) RESIDENCE NO. 552 St. Mary's ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: colord

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Aug 30 1926

7 AGE

| Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|
| | 5 | 11 10 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER: Norwood Payne

11 BIRTHPLACE OF FATHER (city or town) (State or country): Westminster, Md

12 MAIDEN NAME OF MOTHER: Grace Harrison

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Grace Harrison

(Address): 552 St. Mary's St

15 Filed 1-7 1927 H. HANSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 10 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 4, 1927, to Feb 9, 1927, that I last saw h[illegible] alive on Feb 4, 1927 and that death occurred, on the date stated above, at 12 P. m

The CAUSE OF DEATH* was as follows:

Brancho Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H. P. Hughes, M. D.

2/10, 1927 (Address) 825 N. Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: Feb 11 1927

20 UNDERTAKER: Howard Everson

ADDRESS 916 Carey

Cor.—1-12-23—M&T—100 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18880

## CERTIFICATE OF DEATH.

90 E 18880

1-PLACE OF DEATH

REGISTERED NO. 2448

CITY OF BALTIMORE: (No. 413 Lyman ave. Gor. ST., [illegible] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H. Riley

(a) RESIDENCE No 413 Lyman Ave ST., ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Widowed

If married, widowed, or divorced
HUSBAND of (or) WIFE of: Mary O Riley

DATE OF BIRTH (month, day, and year): Dec 11, 1858

| AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 68 | 1 | 28 | |

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: Self.

BIRTHPLACE (city or town) (State or country): Md

10 NAME OF FATHER: James Riley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Margaret Shutridge

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

Informant: Noble L Riley
(Address) 413 Lyman Ave.

Filed 1-12 1927 C. HARRISON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/9 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Coroner, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tabular Disease of Heart

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

(Signed) [signature], M. D.
(Coroner.)

1-12, 1927 (Address) 563 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Friendship, Harford Co | Feb 11 1927 |
| 20 UNDERTAKER | ADDRESS |
| H. Cook | 502 E Monument |

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18881

## CERTIFICATE OF DEATH

E 18881

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2039 N Fulton Ave St. 15-21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elmer C Freeman

(a) RESIDENCE NO. 2039 N. Fulton Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| M | W. | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 13. 1926

| 7 AGE | Years | Months | Days |
|---|---|---|---|
| | | 4 | 24 |

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md

(State or country)

PARENTS

10 NAME OF FATHER Elmer C Freeman

11 BIRTHPLACE OF FATHER (City or town) Balto Md

(State or country)

12 MAIDEN NAME OF MOTHER Pearl E Davis

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country)

14 Informant Elmer C Freeman

(Address) 2039 N Fulton Ave.

Filed FEB 1 1927 19 H. E. [illegible] Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 9 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 8 1927, to Feb 9th 1927, that I last saw him alive on Feb 9th 1927, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows: Broncho-Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) L L Gordy M. D.

2-10, 19 (Address) 4218 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westlawn

Date of Burial Feb 11 1927

20 UNDERTAKER W H Cook

ADDRESS 502 E North Ave

Spec. -7-17-26—A Co.—200 Bks.

3909 Garrison Blvd
656 Ridgely Blvd.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18882

E 18882

## CERTIFICATE OF DEATH

88

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1564 Ridgely St. 21-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret O Coleman

(a) RESIDENCE NO. 1564 Ridgely St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William A. Coleman

6 DATE OF BIRTH (month, day, and year) Sept 24 1900

7 AGE Years: 26 Months: 4 Days: 21 IF LESS than 1 day ....hrs. or ....min.. 14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna

PARENTS

10 NAME OF FATHER John Kumler

11 BIRTHPLACE OF FATHER (City or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary A Horner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant William Coleman (Address) 1564 Ridgely St

15 Filed FEB 1 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 8 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 22nd 1927 to Feb. 8th 1927

that I last saw her alive on Feb. 8th 1927

and that death occurred, on the date stated above, at 6:20 P. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis & Myocarditis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Uremia & Convulsion & Hemiplegia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) F B Coulton M. D.

2/9/1927 (Address) 3909 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Date of Burial Feb 11 1927

20 UNDERTAKER H. Cook ADDRESS 502 E Monroe

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18883

## CERTIFICATE OF DEATH.

E 18883

1-PLACE OF DEATH Maryland General Hospital 11-24

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Betty Menne

(a) RESIDENCE NO. [redacted] Glenndale Ave, ST., Woodlawn, Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? 42 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Herman T. Menne

6 DATE OF BIRTH (month, day, and year) March 16, 1863

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 63 | 10 | 24 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housf. 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Henar Munker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Lotty Ruchet

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Hospital Records

(Address)

15 [illegible] J. HAMPSON JONES, M. D.

Registrar

FEB 11 1927

Per [illegible]

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 10 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 23, 1927, to Feb 10, 1927, that I last saw herAlive on Feb. 10, 1927, and that death occurred, on the date stated above, at 9:15 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Diabetic Gangrene

(duration) yrs. mos. 2 weeks

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes Date of Feb. 7, 1927

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) C. C. Yellowlees, M. D.

, 19 (Address) Md. Gen'l Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Woodlawn Cemetery | Feb 14 1927 |

| UNDERTAKER | ADDRESS |
|---|---|
| Forrest Dyer | Woodlawn Md |

pec.—1-12-23—M&T—500 Blks.

13884

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

19-2774-001

REGISTERED NO. E 13884

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 412 S. Stricker ST., WARD)

2-FULL NAME Neal Dolan

(a) RESIDENCE NO. 412 S. Stricker ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 87 yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced (HUSBAND of) (or) WIFE of: Mr. Elizabeth Dolan

6 DATE OF BIRTH (month, day, and year): Oct. 22-1839

7 AGE: Years 87 | Months 9 | Days 18 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Eng.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): England

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant: Mary Dolan

(Address) 412 S. Stricker St.

15 Filed FEB 11 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 9 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 17, 1927, to Feb 9, 1927.

that I last saw h[illegible] alive on Feb 8, 1927

and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Frank Eugene Blair M. D.

, 19 (Address) 707 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Feb 12 1927

20 UNDERTAKER: Frank Siffer — ADDRESS: 1600 W. Baltimore

Spec- 12-23-21- E.B.R.S.-400 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18885

## CERTIFICATE OF DEATH.

76-2 179 E 18885

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 242 N. Highland ave St., 76-2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... John Williams

(a) Residence No. 242 N. Highland ave St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. — mos. — ds. How long in U. S., if of foreign birth? 13 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Sarah Williams

6-DATE OF BIRTH (month, day and year) 6/30/1853

7-AGE, 73 yrs. 7 mos. 9 ds. If LESS than 1 day, ....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Laborer. Retired

(b) General nature of industry, business, or establishment in which employed (or employer)..... Pharmaceuticals

(c) Name of employer..... Sharp & Dohme

9-BIRTHPLACE (city or town)..... (State or Country), Wales

PARENTS.

10-NAME OF FATHER, John Williams

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Wales

12-MAIDEN NAME OF MOTHER, Hannah Williams

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Wales

14- (Informant)..... Sarah Williams

(Address)..... 242 N. Highland ave

15- Filed..... 1927 C. HAMILTON JONES, M. D. Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 2/9/27

17- I HEREBY CERTIFY, That I attended deceased from July 1st. 1926 to July 9th. 1927

that I last saw him alive on July 9th. 1927

and that death occurred, on the date stated above, at 10.00 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemic poison

(Duration)..... yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Analysis

(Signed) W. H. Jones M. D.

2/10/ 1927 (Address) 1011 N. Ellwood ave.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL. Jan. 12, 1927

Mt. Carmel Cemetery

UNDERTAKER. ADDRESS

Chas. B. Crane & Son 1180 W. Mt. Royal ave

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18886

## CERTIFICATE OF DEATH.

90 E 18886

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 608 Edgewood ST. 20-67 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marcus Marx

(a) RESIDENCE NO. 608 Edgewood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hennie Marx

6 DATE OF BIRTH (month, day, and year) Jany 27 1849

7 AGE — Years: 78 — Months: — — Days: 13 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 066

(b) General nature of industry, business, or establishment in which employed (or employer) Shoe salesman

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Nathan Marx

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rubenson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs H Marx

(Address) 608 Edgewood Rd

FEB 11 1927

H. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 10 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 9th, 1927, to Feb. 10th, 1927,

that I last saw him alive on Feb 10th, 1927,

and that death occurred, on the date stated above, at 11 30 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Coronary Thrombosis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Clark E Heller, M. D.

, 19 (Address) 5838 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship Cem. — DATE OF BURIAL: Feby 13 1927

20 UNDERTAKER: Harry Sondheim — ADDRESS: 1114 W. Lexington St.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

18887

## CERTIFICATE OF DEATH.

37-001. E 18887

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 713 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ireul Phillips

(a) RESIDENCE NO. 1801 E. Madison St. St. Balt. Md. Ward

(Usual place of abode)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. (If non-resident give city or town and State) How long in U. S., If of foreign birth? ____ yrs. ____ mos. ____ ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 9-7-26

7 AGE: Years: 5 mos. Months: 5 Days: 2 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto.

(State or country): Md

PARENTS

10 NAME OF FATHER: Horace Phillips

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Va.

12 MAIDEN NAME OF MOTHER: Mandie Wells

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Va.

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed FEB 11 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 9 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 3, 1927, to Feb 9, 1927, that I last saw him alive on Feb 9, 1927, and that death occurred, on the date stated above, at 30 m.

The CAUSE OF DEATH* was as follows:

Miliary Tuberculosis.

(duration) ____ yrs. ____ mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Xray + [illegible]

(Signed) H. E. Handley, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ashury Cemetery Date of Burial 2/11/27

20 UNDERTAKER: Mrs. R. A. Elliott ADDRESS 1725 Ashland Ave

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18888

## CERTIFICATE OF DEATH.

129

REGISTERED NO. E 18888

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 227 N. Poppleton St. 18-16 Ward)

2-FULL NAME Maggie Callaman

(a) RESIDENCE NO. 227 N. Poppleton St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) (?) 1870

7 AGE: Years 57; Months; Days; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) O

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Davis Gray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Susan Gray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Gertrude Burgan

(Address) 227 N. Poppleton St.

15 Filed 2 11 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 Feb. 8 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1927, to Feb 8, 1927,

that I last saw h.... alive on Feb, 1927

and that death occurred, on the date stated above, at 12.45 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis about

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) O'Hanlon, M. D.

2/11, 19 27 (Address) 805 Hampden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: W. Laurel Cem. Date of Burial 2/11 19 27

20 UNDERTAKER Samuel D. Housley ADDRESS 57 S. Eutaw

Spec.—1-12-23—M&T—500 Bks.

E 18889

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18889

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Joseph's Hospital.

CITY OF BALTIMORE: (No. 29-48 ST.) (WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Armstrong.

(a) RESIDENCE NO. 4722 York Road ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? 84 yrs. mos. ds. (If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Married.

6a If married, widowed or divorced (or) WIFE of Clarence N. Armstrong

6 DATE OF BIRTH (month, day, and year) July 18 1885

7 AGE: Years 41 | Months 6 | Days 28 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John G. Moller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Benedicta Schaefer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Clarence N. Armstrong

(Address) 4722 York Road

15 Filed 3 11 1927 C. THOMPSON JONES, M. D. Per K.L. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/11/ 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 24, 1927, to Feb 11, 1927,

that I last saw her alive on Feb 11, 1927,

and that death occurred, on the date stated above, at 9:10 a m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis.

Peritonitis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(duration) yrs. mos. 2 days

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Jan 24 '27

Was there an autopsy? no Feb 11 '27.

What test confirmed diagnosis? Operation + clinical

(Signed) Clarence R. Morse, M. D.

Feb 11, 1927 (Address) St Joseph's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer Cemetery — DATE OF BURIAL Feb 14 1927

UNDERTAKER Henry Hosch Son — ADDRESS 130 E Eager St

Spec.—7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18890

## CERTIFICATE OF DEATH

74-001 E 18890

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1711 E Lanvale St. 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary T. Schmitt

(a) RESIDENCE NO. 1711 E Lanvale St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. — mos. — ds. How long in U. S. if of foreign birth? 54 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced (or) WIFE of: Louis Schmitt.

6 DATE OF BIRTH (month, day, and year): October 27 1870

7 AGE — Years: 56 Months: 3 Days: 12 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Phila. Pa

PARENTS

10 NAME OF FATHER: Anthony Cohatsic

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Mr. Louis Schmitt.

(Address) 1711 E Lanvale St

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

Per .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): February 9 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 4, 1927 to Feb 9, 1927

that I last saw h..... alive on ..... 19 .....

and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Cardiac Dropsy

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William Rypsamer M. D.

(Address) 801 N Kenwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery Date of Burial: Feb 13 1927

20 UNDERTAKER: Henry Heath Son ADDRESS: 1301 E Eager St

FEB 11 1927

Spec.—12-9-25—A Co.—200 Blks.

E 18891

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129

E 18891

1-PLACE OF DEATH

City of BALTIMORE: (No. 1223 N. Pat. Pk. Ave St. 8-12 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Henry Clemens

(a) RESIDENCE NO. 1223 N. Pat. Pk. Av St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? 45 yrs. ___ mos. ___ ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Johanna M. Clemens

6 DATE OF BIRTH (month, day, and year): Jan 27/60

7 AGE — Years: 67 — Months: — — Days: 12 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer): Red C. Oil Co.

(c) Name of employer

9 BIRTHPLACE (city or town) _____ (State or country): Germany

PARENTS

10 NAME OF FATHER: Frederick Clemens

11 BIRTHPLACE OF FATHER (city or town) _____ (State or country): Germany

12 MAIDEN NAME OF MOTHER: Henriette —

13 BIRTHPLACE OF MOTHER (city or town) _____ (State or country): Germany

14 Informant: Johanna M. Clemens (Address) 1223 N. Pat. Pk Ave

15 Filed 2/9 1927 C. HAMPSON JONES, M. D. Registrar Per _____

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feby 8/27

17 I HEREBY CERTIFY, That I attended deceased from January 3, 1926, to February 8, 1927, that I last saw him alive on February 7, 1927, and that death occurred, on the date stated above, at 11:55 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis & Chronic Interstitial Nephritis

(duration) 6 yrs. 6 mos. ___ ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) ___ yrs. ___ mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) Chas. Sumpter, M. D.

2/9 1927 (Address) 1613 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel — Date of Burial 2/11 1927

20 UNDERTAKER: Philip Herwig — ADDRESS 2016 Orleans St

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18892

## CERTIFICATE OF DEATH.

90 E 18892

REGISTERED NO._____

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St., 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cadie Hunt

(a) RESIDENCE NO. 115 Braxton St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Negro | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Hunt

6 DATE OF BIRTH (month, day, and year) 1880

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 47 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER Johnson Eyres

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Caroline —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant BALTIMORE CITY HOSPITALS

(Address) [redacted]

15 Filed....., 19.... HAMPTON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 8 1927

17

I HEREBY CERTIFY, That I attended deceased from February 8, 1927, to February 8, 1927, that I last saw h.. alive on February 8, 1927, and that death occurred, on the date stated above, at 4:20 p.m.

The CAUSE OF DEATH* was as follows:

Uterine Fibroid

Secondary Anemia

Chronic Myocarditis

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) ...yrs. ...mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? gen'l & Laboratory

(Signed) G. Hooper Lumb M. D.

Feb 10 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Scottsville Virginia Feb 11 1927

20 UNDERTAKER — ADDRESS

Jos. J. H. Rochester. 1143 Jefferson St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18893

## CERTIFICATE OF DEATH.

90 E 18893 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. #2203 Guilford Ave 17-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William G. Brown

(a) RESIDENCE. No. 2203 Guilford ave ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | white | widower |

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of of Millie Brown

6 DATE OF BIRTH (month, day, and year) Dec 10 1846

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 81 | 2 | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll co Md

PARENTS

10 NAME OF FATHER Thomas S. Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll co Md

12 MAIDEN NAME OF MOTHER Alinda Stansbury

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carroll co Md

14 Informant Thomas F. Ensor

(Address) #2203 Guilford ave

15 Filed FEB 11 1927 19 C. HAMPSON JONES, M. D. Registrar

Per Rose

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10 - 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec. 15 1926, to July 10 - 1927.

that I last saw h. alive on July 10 - 1927.

and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Organic heart disease
(Mitral incompetency)

(duration) 4 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Unknown

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Chas Keller, M. D.

2/11. 1927 (Address) 222 W. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Guilford Cemetery Reisterstown — DATE OF BURIAL: Feb 13 1927

20 UNDERTAKER: J. F. Ensor & Sons Reisterstown Md — ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18894

## CERTIFICATE OF DEATH.

101 001 ✓ E 18894

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 531 N. Dallas ST. 7-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Tirdnok Jamsan

(a) RESIDENCE NO. 531 N. Dallas ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs. or min. |
|---|---|---|---|---|
| | 42 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 060

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Henry Jamsan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Sarah Shelton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant James Shelton

(Address) 531 N Dallas St

Filed 2-11 1927. 19 C. HAMPSON JONES, M. D. Registrar

Per LH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 8 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 6 .1927. to Feb. 8 .1927.

that I last saw ~~him~~ alive on Feb 8 .1927.

and that death occurred, on the date stated above, at 4:00 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Robert L Green M. D.

2-10, 1927 (Address) 120 Augusta St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Richmond Co Va

DATE OF BURIAL Feb. 13 1927

UNDERTAKER Robert E Williams

ADDRESS 1515 N McElderry St

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18895

## CERTIFICATE OF DEATH

129 ✓

E 18895

REGISTERED NO.

1-PLACE OF DEATH 214 N. Caroline st

CITY OF BALTIMORE: (No. ..... ST 5-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eleanora Edwards

(a) RESIDENCE NO. 214 N. Caroline ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F. | Colored | married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 9 1877

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 49 | 11 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Eleanora Edwards

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Richard Sims

(Address) 214 N. Caroline St.

15 Filed FEB 1 1927 19

J. THAMPSON JONES, M. D.

Per ..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2 - 9 1927

17 I HEREBY CERTIFY, That I attended deceased from 12 - 14, 1926, to 2 - 9 1927,

that I last saw him alive on 2 - 9, 1927,

and that death occurred, on the date stated above, at 12:25 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

Pul. Edema Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical - Laboratory

(Signed) W B Butler, M. D.

, 19 (Address) 425 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury

DATE OF BURIAL Feb 3 1927

20 UNDERTAKER Robert E. Mullin

ADDRESS 1518 N. Stricker St

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18896

## CERTIFICATE OF DEATH.

129

E 18896 REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1132 Clarkson St. St. 23-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Celia Wheatley.(C)

(a) RESIDENCE NO. 1132 Clarkson St. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female. | Colored | Married. |

5a If married, XXXXXXXXXXXX XXXXXXXXXXX (or) Wife of Jefro Wheatley.(C)

6 DATE OF BIRTH (month, day, and year) August 2, 1870.

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 56 | 6 | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) St.Marys Co.Md.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Do not know.

14 Informant Jefro Wheatley.(C) husband.

(Address) 1132 Clarkson St.

15 Filed B 1 1927 C. HAMPSON JONES, M. D. Per Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 8, 1927. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the Heart and Kidneys.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Wm. Reinhardt M. D. (Coroner)

2/9, 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Lebanon Cemtery Date of Burial 2/12 1927

UNDERTAKER Walter B. Sprigg ADDRESS 139 W. Hamburg St

E 18897

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

14 E 18897

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 732 S. Ann St. 7-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

2-FULL NAME... Mary Wengrzeniak

(Residence in Baltimore: No. 732 S Ann St St.; yrs. 15 mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

| 3-SEX. | 4-COLOR OR RACE. | 5-Single, Married, Widowed, or Divorced, (Write the word.) |
|---|---|---|
| F | W | married |

6-DATE OF BIRTH. ..... 1894 ..... 1 .....
(Month) (Day) (Year)

| 7-AGE. | If LESS than 1 day. |
|---|---|
| 33 yrs. ..... mos. ..... ds. | ....hrs. or....mln.? |

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). Poland

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER, (State or Country). Poland

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter Wengrzeniak

(Address) 732 S Ann St

15-

Filed FEB 1927 C. HAMPSON JONES, M. D. 192

Per ..... Registrar.

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 10 192 7
(Month) (Day) (Year)

17- I HEREBY CERTIFY that I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest Inquest, autopsy or Inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Post. Partum Haemorrhage

(Duration) ..... yrs. ..... mos. 1 ..... ds.

CONTRIBUTORY (Secondary) Shock

(Duration) ..... yrs. ..... mos. ..... ds.

Witness my hand this 11 day of Feb 192 7 (Signed) G E Pardee M. D. (Coroner) (Address) 1476 13 Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

| 19-PLACE OF BURIAL OR REMOVAL. | DATE OF BURIAL. |
|---|---|
| Holy Rosary Cem | Feb 12 1927 |
| 20-UNDERTAKER. | ADDRESS. |
| John F Weber | 1703 Bank St |

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18898

E 18898

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospital Ward)

2-FULL NAME Annie D. Shields

(a) RESIDENCE NO. 1913 Mc Culloh St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Charles W. Shields

6 DATE OF BIRTH (month, day, and year): March 20, 1876.

7 AGE: Years 50. Months 10 Days 19 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Maryland

(State or country)

PARENTS

10 NAME OF FATHER: Washington Stanley

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Maryland

12 MAIDEN NAME OF MOTHER: Louise Ewing

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Maryland

14 Informant: Rebecca Palmer

(Address): 2116 Mc Culloh St

15 1927 C. HAMPSON JONES, M. D.

Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 9, 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 4, 1927, to Feb. 9, 1927, that I last saw h[illegible] alive on Feb. 9, 1927, and that death occurred, on the date stated above, at 4:10 p.m.

The CAUSE OF DEATH* was as follows: Carcinoma of Bladder

Contributory: Anemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No Cystoscopy

What test confirmed diagnosis?

(Signed) [illegible] M. D.

2-10 1927 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional spaces.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: W. Lawn Cemetery Date of Burial Feb. 13 1927

20 UNDERTAKER: Saml. W. Chase & Son ADDRESS 440 Park Ave

Spec.—1-10-21—M&T—1500 Blks.

E 18899

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18899

## CERTIFICATE OF DEATH.

31

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1410 Franklin ST. 14-27 WARD)

2-FULL NAME Mary Kent.

(a) RESIDENCE NO. 1410 Franklin ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. 8 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Colored | Single. |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 15-1908.

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 18 | 8 | 25 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sewing dress 041

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Elite.

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Hilton Kent.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Laura Hilton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Laura Kent. (Address) 1410 Franklin St

15 Filed 1 1927 19 C. HAMPSON JONES, M. D. Registrar Per [illegible]

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 10 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 4, 1927, to Feb 10, 1927, that I last saw h[illegible] alive on Feby 9, 1927 and that death occurred, on the date stated above, at 4.10 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis,

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum

(Signed) Wm. N. Magruder M. D.

Feb 10, 1927 (Address) 1209 Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery — DATE OF BURIAL Feb. 12 1927

20 UNDERTAKER Isaac W. Lee & Son — ADDRESS 1410 Pennsylvania Ave

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18900

## CERTIFICATE OF DEATH.

90 E 18900

1-PLACE OF DEATH

City of BALTIMORE: (No. [redacted] St. 16-37 Ward)

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Charles Haney

(a) RESIDENCE NO. [redacted] St. [redacted] Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widowed |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1863

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 64 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant

(Address)

15 Filed Records FEB 1 1927 C. HAMPSON JONES, M. D. Registrar

Rec'd 10:33 AM

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 9 1927

17 I HEREBY CERTIFY, That I attended deceased from August 20 1925, to February 9, 1927, that I last saw h.wm. alive on February 9, 1927, and that death occurred, on the date stated above, at 11 30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Sclerosis

Chronic Myocarditis & Iron Poisoning

(duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death!

Did an operation precede death! no Date of

Was there an autopsy! no

What test confirmed diagnosis? general laboratory

(Signed) C. Hooper Lund, M. D.

Feb 10 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

FEB 11 1927

Spec.—1-12-23—M&T—500 Bks.

E 18901

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 18901

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1817 Kavanaugh St. 15-21 Ward)

2-FULL NAME Baby Dorsey

(a) RESIDENCE No. 1817 Kavanaugh St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year): 2-10-27

7 AGE: Years | Months | Days | If LESS than 1 day, hrs. or min.: 4 hrs.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer): Infant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): 1817 Kavanaugh Baltimore Md

PARENTS

10 NAME OF FATHER: George Dorsey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Gallon Ky

12 MAIDEN NAME OF MOTHER: Margaret Brooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pikeville Md

14 Informant: Margaret Dorsey

(Address) 1817 Kavanaugh St.

15 Filed 1927 10:34 A.M. C. HAMPSON JONES, M. D. Registrar

Per ard

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2-10-1927

17 I HEREBY CERTIFY, That I attended deceased from 2/10, 1927 to 2/10, 1927

that I last saw him alive on 2/10, 1927, 19

and that death occurred, on the date stated above, at 5:15 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. Alexander Novey, M. D.

, 19 (Address) 1516 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: HOPKINS HOSPITAL

DATE OF BURIAL: 19

20 UNDERTAKER: Commissioner Health

ADDRESS

FEB 1 - 1927

Spec.—12-0-33—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

200 18902

## CERTIFICATE OF DEATH.

49 E 18902

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 13-59 Ward)

2-FULL NAME Jacob W. Meyers

(a) RESIDENCE NO. 2833 Woodbrook Ave St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): Widowed -

3a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rachel A. Meyers

6 DATE OF BIRTH (month, day, and year): 9-14-1839

7 AGE: Years 87 | Months 4 | Days 28 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired - 31

(b) General nature of industry, business, or establishment in which employed (or employer): Machinist

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore,

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Frederick Meyers -

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Margaret Heuter

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md.

14 Informant: Records -

(Address) JOHNS HOPKINS HOSPITAL

FILED 1 1 1927

19 C. HAMPSON JONES, M. D. Registrar

Per Asst

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 Feb 11

17 I HEREBY CERTIFY, That I attended deceased from Feb 9, 1927, to Feb 11, 1927, that I last saw h[illegible] alive on Feb 11, 1927, and that death occurred, on the date stated above, at 2.43 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate

Myocardial Failure

(duration) 12 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pyelonephritis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? 2

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) F. W. Schacht, M. D.

2-11 1927 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cemetery — Date of Burial: Feb. 14 1927

20 UNDERTAKER: Joseph B. Cook — ADDRESS 1003 N. Dallas St

Spec.—1-12-23—M&T—500 Blks.

18903

# HEALTH DEPARTMENT—CITY OF BALTIMORE

18903

## CERTIFICATE OF DEATH.

129E

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 125 N. Fulton Ave., ST. 19-27 WARD)

2-FULL NAME Mary E. Hubbard

(a) RESIDENCE NO. 125 N. Fulton Ave., ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Husband.

6 DATE OF BIRTH (month, day, and year) Oct.7th.1863

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 63 | 4 | 2 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dorchester co. Maryland.

PARENTS

10 NAME OF FATHER William Sanders

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Lillie Christofer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Mrs. Richard Donnelly
(Address) 125 N. Fulton Ave.

15 1927 C. HAMPSON JONES, M. D. Registrar
Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb.9, 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb.7th. 1927 to Feb.9th 1927.

that I last saw her alive on Feb.9th 1927

and that death occurred, on the date stated above, at 8:45P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Can Newcomer M. D.

2/11/27 (Address) 2411 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral DATE OF BURIAL Feb. 12 1927

20 UNDERTAKER George L. Schwab ADDRESS 1101 Eutaw Ave

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18904

## CERTIFICATE OF DEATH

129 E 18904

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 828 N Washington St Ward 12)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Drucilla Crawford

(a) RESIDENCE NO. 828 N. Washington St Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Crawford

6 DATE OF BIRTH (month, day, and year) Unknown 1868

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|---|
| | 58 | 59 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va

(State or country)

PARENTS

10 NAME OF FATHER Charles Higgs

11 BIRTHPLACE OF FATHER (City or town) Va

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown

(State or country)

14 Informant Edna Mick

(Address) 828 or 826 Washington

15 Filed FEB 1 1927 C. HAMPSON JONES, M. D. Registrar

Per A C R

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 10 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 3, 1927, to Feb. 10, 1927.

that I last saw her alive on Feb. 10, 1927, and that death occurred, on the date stated above, at 5 00 A. m.

The CAUSE OF DEATH* was as follows:

Acute Uraemia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Paranephritis Nephritis

Arterial Hypertension ?

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Joseph Pakarsky M. D.

, 19 (Address) 2200 E Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Hampden Date of Burial Feb 13 1927

20 UNDERTAKER Thanhouser Son ADDRESS 3617 Chestnut Ave

very important. See instructions on back of certificates.

Spec.—12-9-25—A.C.—200 Bks.

E 9878
E 18905

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

X 84 E 18905

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

City of BALTIMORE: (No. _____ St., 7-9 Ward)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harold Elliott

(a) RESIDENCE NO. 25 Weymouth Ave Venice, N.J.
(Usual place of abode) St. _____ Ward _____
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 ~~Single~~, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret Veatch

6 DATE OF BIRTH (month, day, and year): Sept 23, 1891

7 AGE: Years 35 | Months 4 | Days 18 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: School Teacher
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town): _____
(State or country): N. Y.

PARENTS

10 NAME OF FATHER: Edgar Elliott

11 BIRTHPLACE OF FATHER (city or town): _____
(State or country): N. Y.

12 MAIDEN NAME OF MOTHER: Ida Foulk

13 BIRTHPLACE OF MOTHER (city or town): _____
(State or country): N. Y.

14 Informant: Records
(Address) JOHNS HOPKINS HOSPITAL

FEB 1 1927 C. HAMPSON JONES, M. D.
Per ORN Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 Feb. 11

17 I HEREBY CERTIFY, That I attended deceased from Feb 4, 1927, to Feb. 11, 1927, that I last saw h~~im~~ alive on Feb. 11, 1927, and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Brain Tumor - benign

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Postpenetine thrombosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? N Y

Did an operation precede death? Yes Date of Feb 11-1927

Was there an autopsy? Yes

What test confirmed diagnosis? Path Exam

(Signed) Warfield M Theobald, M. D.

, 19 (Address) JHH

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Potsdam, N. Y. Date of Burial: Feb. 19 27

20 UNDERTAKER: John C Mitchell ADDRESS: 1956 Eutaw Pl

Very Important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18906

E 18906

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 147 N. Curley St St., 6-11 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph C. Spiegel

(a) RESIDENCE NO. 147 N. Curley St St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 9 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| male | white | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Christina Spiegel

6 DATE OF BIRTH (month, day, and year) May 23/1862

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 64 | 8 | 17 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman do

(b) General nature of industry, business, or establishment in which employed (or employer) Guano Factory

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) Md.

PARENTS

10 NAME OF FATHER Alexander Spiegel

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Germany

12 MAIDEN NAME OF MOTHER Geneva Straub

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Germany

14 Informant John Spiegel

(Address) 147 N. Curley St

1927 C. HAMPSON JONES, M. D.

Per _____ Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 10 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr Myocarditis

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) J. S. Hampson Jones M. D.

(Coroner)

2/11/27 (Address) 508 E. Nor h Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Pk

Date of Burial Feb 12 1927

20 UNDERTAKER I Kew McCauley ADDRESS 128 E. Mont.

Very Important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18907

E 18907

## CERTIFICATE OF DEATH.

129

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St., 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth De Fazio

(a) RESIDENCE NO. 1508 E Lafayette St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? 20 yrs. ____ mos. ____ ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dominick De Fazio

6 DATE OF BIRTH (month, day, and year) 10/14/1868

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 58 | 3 | 26 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Italy

PARENTS

10 NAME OF FATHER Michael Bonadio

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Italy

12 MAIDEN NAME OF MOTHER Leazer Bondee

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Italy

14 Informant Rose De Cicco

(Address) 1508 E Lafayette Ave

I hereby ... C. HAMPSON JONES, M. D. Registrar

2 1927

Per _____

very important. See instructions on back of certificate.

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 9 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Albuminuria

Albuminuria (Duration) yrs. ____ mos. 1 ds.

CONTRIBUTORY (Secondary) _____ (Duration) yrs. ____ mos. ____ ds.

(Signed) G C Trader (Coroner) M. D.

2/27 (Address) 143 N Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem Date of Burial 2/14 1927

20 UNDERTAKER George F Ruth ADDRESS 1735 Fleet Ave

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18908

## CERTIFICATE OF DEATH.

E 18908

REGISTERED NO. 15-21/62

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1716 Pennsylvania ST., 15-21 WARD)

2-FULL NAME Baby Johnson.

(a) RESIDENCE NO. 1716 Pennsylvania ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year): 2/14/27

7 AGE — Years — Months — Days: 6 — If LESS than 1 day, hrs. or .. min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Benj. Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Anne Arundel Co. Md.

12 MAIDEN NAME OF MOTHER: Mary Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore, Maryland

14 Informant (Address): Mary Johnson 1716 Pennsylvania Ave

15 Filed FEB 2 1927. C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/10 19 27

17 I HEREBY CERTIFY, That I attended deceased from 2/4, 19 27, to 2/10, 19 27, that I last saw h[illegible] alive on 2/10, 19 27, and that death occurred, on the date stated above, at 12:45 P. m.

The CAUSE OF DEATH* was as follows:

Congenital atelectasis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. Alexander Morey, M. D.

, 19 (Address) 1516 Madison ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND.

DATE OF BURIAL, 19: FEB 11 1927

20 UNDERTAKER

ADDRESS

Commissioner Health.

Spec.—12-9-25—A Co.—200 Bks.

E 18909

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18909

## CERTIFICATE OF DEATH.

24-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 4010. Boarmon ave St., 15-63 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Concetta Maranto

(a) RESIDENCE NO. 4010 Boarmon. ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Femal

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Giuseppe Maranto

6 DATE OF BIRTH (month, day, and year): June 16th 1851

7 AGE: 75 Years | Months: 7 | Days: 26 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: H. W.

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town): Italy

(State or country)

PARENTS

10 NAME OF FATHER: Joseph Piazza

11 BIRTHPLACE OF FATHER (city or town): Italy

(State or country)

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): Italy

(State or country)

14 Informant: Frank maranto

(Address) 4010. Boarmon ave

15 1927 C. HAMPSON JONES, M. D.

Per RLS Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/11 1927

17 I HEREBY CERTIFY, That I attended deceased from Feby 5 1927, to Feby 10, 1927, that I last saw h.. alive on Feby 10, 1927 and that death occurred, on the date stated above, at 5. A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary): Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jos. A. Valentine M. D., M. D.

Feb 12 1927. (Address) 1450 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — Date of Burial: 2/14 1927

20 UNDERTAKER: Geo. J. Ruth — ADDRESS: 1735 Harford ave

Very Important. See instructions on back of Certificate.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18910

## CERTIFICATE OF DEATH.

129 E 18910

26-37

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 3rd & St. Joseph St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME H. D. William Geidt

(a) RESIDENCE NO. 416 S 13th St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emily Geidt

6 DATE OF BIRTH (month, day, and year) June 3. 1859

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 67 | 8 | 8 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor - Retired 6 mo

(b) General nature of industry, business, or establishment in which employed (or employer) Tin Mill

(c) Name of employer Sparrows Point Plant.

9 BIRTHPLACE (city or town)

(State or country) Baltimore

PARENTS

10 NAME OF FATHER Philip Geidt

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Not Known

14 Informant Emily Geidt

(Address) 416 S. 13th St.

C. HAMPSON JONES, M. D.

Registrar

2 1927

Very important. See instructions on back of certificate.

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

Chronic Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) James H. Jenkins M. D.

(Coroner)

2 (7, 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

Date of Burial Feb 13 1927

20 UNDERTAKER Henry Sander & Sons Inc

ADDRESS 1710 Fleet St.

Spec.—1-10-21—M&T—1500 Blks.

E 18911 HEALTH DEPARTMENT—CITY OF BALTIMORE E 18911

## CERTIFICATE OF DEATH.

2-4 129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1612 Thames St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Weber

(a) RESIDENCE NO. 1612 Thames ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Constance Weber

6 DATE OF BIRTH (month, day, and year) Aug 1 - 1860

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ... min. |
|---|---|---|---|---|
| | 66 | 6 | 9 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer do

(b) General nature of industry, business, or establishment in which employed (or employer) any kind

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Constance Weber

(Address) 1612 Thames St

15 2 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 10 / 1927.

17 I HEREBY CERTIFY, That I attended deceased from about 1924 to Feb 10 / 1927.

that I last saw him alive on Feb 8 / 1927.

and that death occurred, on the date stated above, at 10:30 Am.

The CAUSE OF DEATH* was as follows:

Chr. Int. Nephritis

(duration) 3 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) — yrs — mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. T. Rogers, M. D.

, 19 (Address) 1904 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Holy Rosary | Feb 14 1927 |
| 20 UNDERTAKER | ADDRESS |
| John M. Weber | 1803 Bank St |

Spec.—12-9-25—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18912

101-201

E 18912

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1812 White st St. 7-27 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Smith

(a) RESIDENCE NO. 1812 White st St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. ds. 4 How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec 8, 1926

7 AGE — Years: — Months: 3 — Days: 4 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: no

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): md

PARENTS

10 NAME OF FATHER: William Smith

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Ga

12 MAIDEN NAME OF MOTHER: Alice Davis

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Ga

14 Informant: Alice Smith

(Address): 1812 White st

2 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 12 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1927, to Feb 12, 1927, that I last saw h[illegible] alive on Feb 11, 1927, and that death occurred, on the date stated above, at 12:30 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia and Pulmonary Congestion

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary): General Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death] unknown

Did an operation precede death] no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) G. H. Hall, M. D.

, 19 (Address) 1626 E 30th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Zion — Date of Burial: 2-12 1927

20 UNDERTAKER: Joseph A Lively — ADDRESS: 409½ Mun. 1 st

Very Important. See Instructions on Back of Certificate.

Spec.—1-12-23—M&T—500 Bks.

E 18913

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18913

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bon Secours Hospital

REGISTERED NO. 14-28

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. ..... (WARD)

2-FULL NAME Michael J. Corcoran

(a) RESIDENCE NO. 1608 Wilkins Ave. ST., ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 28 yrs. ..... mos. ..... ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | White | Widowed |

5a If married, widowed, or divorced HUSBAND of or) WIFE of Sarah Corcoran

6 DATE OF BIRTH (month, day, and year) Nov. 25, 1883

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 43 | 2 | 17 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barbermaker

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Martin Corcoran

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Cullen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Thos Corcoran 1608 Wilkins Ave

15 FEB 21 1927 C. HAMPSON JONES, M. D. Registrar

Per .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 11 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan. 21, 1927, to Feb. 11, 1927, that I last saw him alive on Feb. 10, 1927, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Subacute mastoiditis

(duration) ... yrs. 1 mos 20 ds.

CONTRIBUTORY (Secondary) Sinus thrombosis of lat. sinus

(duration) ... yrs. ... mos. 7 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of Jan. 27, '27

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical + Autopsy

(Signed) Geo. D. Lippy, M. D.

, 19 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Haverhill Mass. DATE OF BURIAL 2/13 1927

20 UNDERTAKER Forsyth Funeral Home ADDRESS Baltimore Md.

Spec.—1-10-21—M&T—1500 Blks.

E 18914

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18914

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5702 Gobb St. WARD 27th 4th

REGISTERED NO. 124

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Frederika Reisinger

(a) RESIDENCE No. 5702 Gobb Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced (or) WIFE of: Matthew Reisinger

6 DATE OF BIRTH (month, day, and year): Jan 5, 1849

7 AGE: Years 78 Months 1 Days 5 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Johannes Freindel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Elz. X Schöel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Matthew Reisinger

(Address) 5702 Gobb Ave

15 2 1927

C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/10 1927

17 I HEREBY CERTIFY, That I attended deceased from 1/20, 1927, to 2/10, 1927, that I last saw h[illegible] alive on 2/10/, 1927 and that death occurred, on the date stated above, at 10 30 a. m.

The CAUSE OF DEATH* was as follows:

Acute Pericarditis

(cause unknown)

Chronic Interstitial Nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Kyle R. Holley M. D.

, 19 (Address) 5012 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cem

DATE OF BURIAL: Feby 8 1927

20 UNDERTAKER: John Ellerich

ADDRESS: 2008 Orleans

Cor.—12-9-25—A Co.—200 Bks.

E 18915

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18915

## CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 709 N. Fremont St. 17-23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Worsey

(a) RESIDENCE NO. 709 N. Fremont St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not known

6 DATE OF BIRTH (month, day, and year) September 1857

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 70 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hunter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant John Worsey

(Address) 709 N. Fremont Ave

C. HAMPSON JONES, M. D.

2 1927 Per ——— Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest

(Inquest, autopsy or inquiry.) find that said deceased came to h... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

(Signed) J. T. Hamman, M. D.

(Coroner)

Feb 17 1927 (Address) 250 E. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel. Date of Burial Feb 17 1927

20 UNDERTAKER Jesse T. Riddle ADDRESS 436 E. Lanvale St

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18916

## CERTIFICATE OF DEATH.

11-001 E 18916

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 1022 Park Ave (St.) 11-24 (WARD)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence Roane Brooks

(a) RESIDENCE NO. 1022 Park ave ST., ..... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | Colored | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Jan 24 - 1905

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| 22 | [redacted] | [redacted] | 16 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bellman 086

(b) General nature of industry, business, or establishment in which employed (or employer) Hotel

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Charles G. Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Nina Roane

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Nina Brooks Robertson
(Address) 1022 Park Ave

15 Filed 1 2 1927 G. HAMPSON JONES, Registrar
Per ....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2 - 10 - 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 24th, 1927, to Feb 10th, 1927, that I last saw him alive on Feb 10th, 1927, and that death occurred, on the date stated above, at 12:40 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 17 ds.

CONTRIBUTORY (Secondary) La Grippe

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? 1022 Park ave

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Jos Layne, M. D.

19 (Address) 1063 North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Laurel Cem | 2/14 1927 |
| 20 UNDERTAKER | ADDRESS |
| Emmert L. Kressley | 5 S Bond |

IMPORTANT. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

(over)

E. 18917

# HEALTH DEPARTMENT—CITY OF BALTIMORE

91-61

E 18917

## CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2765 Alameda Boulevard Ward) 9-46

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Arthur Thompson

(a) RESIDENCE NO. 2765 Alameda Boulevard St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 3 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosalie M. Thompson

6 DATE OF BIRTH (month, day, and year) Nov 11 ~~1850~~ 1855

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| ~~74~~ 76 | 76 | 3 | 0 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Arthur Edward Thompson

11 BIRTHPLACE OF FATHER (city or town) Ireland

(State or country)

12 MAIDEN NAME OF MOTHER Louise Biggs

13 BIRTHPLACE OF MOTHER (city or town) Frederick Co Md

(State or country)

14 Informant Edsie M. Thompson

(Address) 2765 Alameda Blvd

2 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 15 1926, to Feb 11 1927, that I last saw him alive on Feb 11 1927, and that death occurred, on the date stated above, at 11:40 A.m.

The CAUSE OF DEATH* was as follows:

Aneurysm thoracic aorta

(duration) 2 yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

2/12, 1927 (Signed) Fritz J Kinzey, M. D.

(Address) 2700 Hoffman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery Date of Burial Feby 14 1927

20 UNDERTAKER Chas. G. Black ADDRESS 142 W. Worth Ave

Very important. See instructions on back of Certificates.

Spec.—1-12-23—M&T—500 Bks.

E 18918 HEALTH DEPARTMENT—CITY OF BALTIMORE E 18918

# CERTIFICATE OF DEATH

118-002

1-PLACE OF DEATH Union Memorial Hospital

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Calvert & 33rd St ST. 17-24 WARD)

Alma Hood

2-FULL NAME Mrs John G. Alexander

(a) RESIDENCE NO. Guilford Ave, Balto Co ST. Md WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [redacted] yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | married |

5a If married, widowed, or divorced BUSBAND of (or) WIFE of John G Alexander

6 DATE OF BIRTH (month, day, and year) March 5, 1892

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 34 | 11 | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard Co Md.

PARENTS

10 NAME OF FATHER Thomas J Hood

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Daisy Motwell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Deceased (Address)

15 Filed Feb 21 1927 C. HAMPSON JONES, M. D. Registrar Per

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 10 1927 to Feb 11 1927 that I last saw her alive on Feb 11 1927 and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows: Intestinal Obstruction

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Feb 10, 1927

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J Geraghty, M. D.

, 19 (Address) Union Memorial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Prospect Hill Cemetery Lauraton Md

DATE OF BURIAL Feby 13 1927

20 UNDERTAKER Chas. S. Black

ADDRESS 142 N. North ave

Spec.—1-10-21—M&T—1500 Bks.

18919

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18919

## CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1819 Guilford Ave ST. 12-19 WARD)

2-FULL NAME Fannie S. Groverman

(a) RESIDENCE NO. 1819 Guilford Ave ST., ..... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Richard H. Groverman

6 DATE OF BIRTH (month, day, and year): June 5. 1845

7 AGE

| Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|
| 81 | 8 | 5 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Selden

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): "

14 Informant: Wm H. Crane

(Address): Hamilton Boro Baltimore

15 FILED 2 1927

C. HAMPSON JONES, M. D.

Per ..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feby 10 1927

I HEREBY CERTIFY, That I attended deceased from Feby 1st, 1927, to Feby 10th, 1927, that I last saw her alive on Feby 10th, 1927, and that death occurred, on the date stated above, at 10.40 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(duration) yrs. 7 mos. 4 ds.

CONTRIBUTORY (Secondary): Senile Debility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo. H. Waterman M. D.

19 (Address) 1801 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cem. | DATE OF BURIAL: Feb 12 1927

20 UNDERTAKER: John O. Mitchell | ADDRESS: 1900 E. Eutaw Sta

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18920

## CERTIFICATE OF DEATH.

E 18920

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2112 W. North ave. ST. 15-66 WARD)

2-FULL NAME Howard B. Kirschampel

(a) RESIDENCE NO. 2112 W. North ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lelia Kratz Kirschampel

6 DATE OF BIRTH (month, day, and year): May 9, 1848

7 AGE — Years: 78 — Months: 9 — Days: 1 — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: John F. Kirschampel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Kohler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Lelia K. Kirschampel

(Address): 2112 W. North Ave

15 Filed: 2 1927

C. HAMPSON JONES, M. D.

Per ____ Registrar.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feby 10 1927

17 I HEREBY CERTIFY, That I attended deceased from several years to Feby. 10, 1927.

that I last saw him alive on Feby 10, 1927.

and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy. - third attack.

Last attack (duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis. (duration) several yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of X

Was there an autopsy? No.

What test confirmed diagnosis? Symptoms only.

(Signed) O. St. Hoffman, M. D.

, 19 (Address) 2301 Harrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemetery

DATE OF BURIAL: Feby 12 1927

20 UNDERTAKER: John O'Neill

ADDRESS: 1906 Eastern Ave

Cor.—12-9-25—A Co.—200 Bks.

E 18921

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 18921

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Church Court St., 7-24 Ward)

2-FULL NAME Magdalena Robeson

(a) RESIDENCE NO. Church Court St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year): about 1879

7 AGE: Years: about 48 Months: Days: IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country) Dist. Maryland

PARENTS

10 NAME OF FATHER Henry Ermeten

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Pfiffer

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Maryland

14 Informant Richard Ermeten

(Address) 2539 Francis Street

15 Filed ..... 19.. THOMPSON JONES, M. D.

Per RPH Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Feb. 10, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said inquest, autopsy or inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) no history

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Henderson M. D.

(Coroner)

Feb. 17, 1927 (Address) 280 E. Eager Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemetery Date of Burial 2/12 1927

20 UNDERTAKER: William Cook ADDRESS 501 E. Fayette

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18922

## CERTIFICATE OF DEATH.

90

E 18922

1-PLACE OF DEATH

City of BALTIMORE: (No. 2547 West North Ave St., 15-68 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William C Askins

(a) RESIDENCE NO. 2547 West North Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kate Askins

6 DATE OF BIRTH (month, day, and year) Nov 10, 1843

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 83 | 2 | 1 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate, Retired

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer Self

9 BIRTHPLACE (city or town) Va

(State or country)

PARENTS

10 NAME OF FATHER Benjamin Askins

11 BIRTHPLACE OF FATHER (city or town) Va

(State or country)

12 MAIDEN NAME OF MOTHER Frances R Talmon

13 BIRTHPLACE OF MOTHER (city or town) Va

(State or country)

14 Informant (Kate R Askins)

(Address) 2547 W North Ave

Feb 12 1927

C. HAMPSON JONES, M. D.

Per DCR Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest

(Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said inquest (autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. myocardial degeneration

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.

(Coroner)

1927 (Address) 780 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine — Date of Burial Feb 14 1927

20 UNDERTAKER H. M. Cook — ADDRESS 507 E North Ave

very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18923

## CERTIFICATE OF DEATH

E 18923

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2529 E Biddle St. 8-12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George L Dieterich

(a) RESIDENCE NO. 2529 E Biddle St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary C Dieterich

6 DATE OF BIRTH (month, day, and year): Oct 8 1876

7 AGE: Years 50 Months 4 Days 2 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Yellow Cab

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Geo F Dieterich

11 BIRTHPLACE OF FATHER (City or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary E Kettler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Lester Dieterich (Address) 2529 E Biddle St

15 Filed 2 1927

C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 10 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1926 to Feb 10 1927, that I last saw him alive on Feb 10 1927, and that death occurred, on the date stated above, at 5-20 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

acute Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): acute Lobar Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) T. Hale Kettler M. D.

Feb 21, 1927 (Address) 710 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western — Date of Burial: Feb 14 1927

20 UNDERTAKER: W. Cook — ADDRESS: 500 E Monument

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 18924

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 18924

REGISTERED NO.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [illegible] St. 11-7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Williams

(a) RESIDENCE NO. 508 N. Calvert St. Ward

(Usual place of abode) ?

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 70 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Oyster dealer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Williams

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Maryland

14 Informant (Address) Records BALTIMORE CITY HOSPITALS

15 Filed 2 1927 By C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 Feb 11,

17 I HEREBY CERTIFY, That I attended deceased from Oct. 20, 1926, to Dec. 10, 1926, that I last saw him alive on Dec 10, 1926 and that death occurred, on the date stated above, at 1.20 P. m.

The CAUSE OF DEATH* was as follows:

Emphysema,
Cerebral Sclerosis
Chronic Myocarditis & Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? (?)

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? general & laboratory

(Signed) R. Hooper Lintl, M. D.

Feb 11, 1927 Address BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — Date of Burial 2/14 1927

20 UNDERTAKER: Wm Cook — ADDRESS 502 E. Monument

Very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

E 18925

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

145-003

E 18925

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital. St., 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Nettie Smith

(a) RESIDENCE NO. 1431 Lanvale St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Black

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of James Smith

6 DATE OF BIRTH (month, day, and year): Aug. 5, 1894

7 AGE: Years 33 | Months 6 | Days 15 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Virginia

PARENTS

10 NAME OF FATHER Lloyd Barker

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Va.

12 MAIDEN NAME OF MOTHER Marie Whittier

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Va.

14 Informant C. H. Williams

(Address) Johns Hopkins Hospital.

15 Filed JOHNS HOPKINS HOSPITAL FEB 12 1927 Registrar

FEB 12 1927 C. HAMPSON JONES, M. D. Per

1037

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 20 19 27

17 I HEREBY CERTIFY, That I attended deceased from 1-17, 19 27, to 1-20, 19 27, that I last saw her alive on 1-20, 19 27, and that death occurred, on the date stated above, at 4 45 A.m.

The CAUSE OF DEATH* was as follows:

Acute myocardial failure

(following childbirth)

(duration) yrs. mos. 1 ds.

CONTRIBITORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. H. Williams, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial FEB 12 1927, 19

20 UNDERTAKER

ADDRESS

Commissioner of Health

Very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18926 | 21 E 18926

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3520 Mt. Pleasant ave (Ward) 76-37

2-FULL NAME Christina M. Rehberger

(a) RESIDENCE No. 3520 Mt. Pleasant ave (Usual place of abode) WARD

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 10-1927

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | — | 1 | 2 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Wm. C. Rehberger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md.

12 MAIDEN NAME OF MOTHER Christine M. Blume

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, Md.

14 Informant Wm. C. Rehberger

(Address) 3520 Mt. Pleasant ave.

15 2 1927 C. HAMPSON JONES, M. D. Registrar

Por RCH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 12 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 8 1927, to Feb. 12 1927, that I last saw h[illegible] alive on Feb. 11 1927 and that death occurred, on the date stated above, at 5 03 A. m.

The CAUSE OF DEATH* was as follows:

Empisalaus

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. M. Hermann, M. D.

(Address) 7913 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Most Holy Redeemer Cem

DATE OF BURIAL Feb. 12 1927

20 UNDERTAKER Zirkler + Zirkler

ADDRESS 1739 E. Eager St.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

18927

## CERTIFICATE OF DEATH.

90 E 18927

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Rear of 800 Block McCabe Ave St. 27-48 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME LLoyd N. Randall

(a) RESIDENCE NO. 800 Block McCabe Ave St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | white | widower |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Randall

6 DATE OF BIRTH (month, day, and year) Nov 6/1850

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 76 | 3 | 5 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer C&O

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto. Co., Md

PARENTS

10 NAME OF FATHER Lloyd N. Randall

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto. Co., Md

12 MAIDEN NAME OF MOTHER Rachel Ward

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto. Co., Md

14 Informant Millard A. Randall

(Address) 800 Block McCabe Ave

C. HAMPSON JONES, M. D.

2 1927 Per _____ Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocarditis

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) J. H. Roll, M. D. (Coroner)

2/12/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woods Chapel Date of Burial 2/13 1927

20 UNDERTAKER Wm Cook ADDRESS 502 E North Ave

very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 18928

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18928

## CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 621 Wyeth St. (St.) (Ward) 24-30

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Virginia Shilow

(a) RESIDENCE. No. 621 Wyeth St. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 26 1926

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 1 ~~Yrs~~ | Feb 11 mos | 15 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wilmer Shilow

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Carrie M. Bell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Wilmer Shilow
(Address) 621 Wyeth St

Filed FEB 2 1927 19 C. HAMPSON JONES, M. D. Registrar
Per ARW

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 17, 1926, to Feb 11, 1927, that I last saw h~~er~~ alive on Feb 11 1927, and that death occurred, on the date stated above, at 6:00 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) — yrs. 1 mos. 25 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Dan Compton, M. D.

2/14 1927 (Address) 57 Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Loudon Park | 2/14/27 |
| 20 UNDERTAKER W. W. Cook | ADDRESS 502 E Lex |

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18929

## CERTIFICATE OF DEATH.

X 84 E 18929

1-PLACE OF DEATH En route Union Sta. to Johns Hopkins Hosp REGISTERED NO.

City of BALTIMORE: (No. 7-9 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fred Hocking

(a) RESIDENCE NO. 1517 6th. St Madison Ill St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nina Hocking

6 DATE OF BIRTH (month, day, and year) Nov. 28. 1888

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 38 | 2 | 15 (14) | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Switchman (13)

(b) General nature of industry, business, or establishment in which employed (or employer) Terminal R.R.

(c) Name of employer Madison Ill

9 BIRTHPLACE (city or town) Bradford Pa

(State or country)

PARENTS

10 NAME OF FATHER John Hocking

11 BIRTHPLACE OF FATHER (city or town)

(State or country) England

12 MAIDEN NAME OF MOTHER Selina Maynard

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Canada

14 Informant Nina Hocking

(Address) St Louis Mo

15 Filed FEB 13 1927 C. HAMPSON JONES, M. D.

Per K/C Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/12 1927

17 I HEREBY CERTIFY, That I took charge of the remains deseribed above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cyst of Cerebellum

(Autopsy at Hopkins)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. H. Cain M. D.

(Coroner)

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ..... mos., ..... ds. In the state ..... yrs., ..... mos., ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Madison Co Ill ~~St. Louis Mo~~ Date of Burial Feb 14th 1927

20 UNDERTAKER ROBT. BROOKS SON ADDRESS CALHOUN HOLLINS

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 18930

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

71-001

REGISTERED NO. E 18930

1-PLACE OF DEATH

City of BALTIMORE: (No. 15 N. Collington Ave St. 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sylvia Agatstein

(a) RESIDENCE NO. 15 N. Collington Ave St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | white | single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 16/1924

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 2 | 8 | 25 26 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md

PARENTS

10 NAME OF FATHER Max Agatstein

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Yetta Sugarman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Max Agatstein

(Address) 15 N. Collington Ave

15 Filed FEB 13 1927 19 C. HAMPSON JONES, M. D. Registrar

Per _____

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11/27 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Meningitis (secondary)

(Reported to have benn treated at Hopkins for anemia)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Paul (Coroner) M. D.

2/12/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Montefiore Cem. Date of Burial 2-13 1927

20 UNDERTAKER Jack Levin ADDRESS 1439 E. Balto.

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 18931

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 E 18931

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2850 Mayfield Ave. (ST.) (WARD) 45

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Maud Roberts

(a) RESIDENCE No. 2850 Mayfield Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel V. Roberts

6 DATE OF BIRTH (month, day, and year) July 31st 1879

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 47 | 6 | 11/12 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Kent Co. Virginia

PARENTS

10 NAME OF FATHER George R. Hazelwood

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Kent Co. Virginia

12 MAIDEN NAME OF MOTHER Milesia A. Richardson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Kent Co. Virginia

14 Informant Samuel V. Roberts

(Address) 2850 Mayfield Ave

15 Filed FEB 13 1927 C. HAMPSON JONES, M. D. Registrar

Per R.R.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12 1927

17 I HEREBY CERTIFY, That I attended deceased from July, 1926, to Feb 12, 1927, that I last saw her alive on Feb 12th, 1927, and that death occurred, on the date stated above, at 9:15 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency.

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum & X-Ray

(Signed) Sam F. Rummel & Simpson M. D.

19 (Address) 722 W. Lanvale Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery — DATE OF BURIAL Feb. 14 1927

20 UNDERTAKER Frederick Lassahn & Sons — ADDRESS Fulton

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18932

## CERTIFICATE OF DEATH.

185 E 18932

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Balto City Hospital St. 5-8 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Victoria Chase

(a) RESIDENCE NO. 229 Colvin St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | Colored | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Evan Chase

6 DATE OF BIRTH (month, day, and year) 1882

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 45 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) At home work

(c) Name of employer

9 BIRTHPLACE (city or town) Salta md

(State or country)

PARENTS

10 NAME OF FATHER Carberry Ford

11 BIRTHPLACE OF FATHER (city or town)

(State or country) md

12 MAIDEN NAME OF MOTHER Hester Smith

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Estelle Brown

(Address) 5214 Eden St

15 Filed ..... 192.. ..... Registrar

FEB 13 1927 C. HAMPTON JONES M. D.

Per

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Fracture of vertebra by accidently falling down stairs at 229 Colvin

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia

(duration) yrs. 2 mos. 6 ds.

(Signed) John W. Finton M. D.

(Coroner)

2-12-1927 (Address) 702 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 229 Colvin St

Former or usual residence "

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel cemetery Date of Burial Feb 14 1927

20 UNDERTAKER Edward Bryan ADDRESS 1631 Orleans St

Cor.—12-9-25—A Co.—200 Bks. ... very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18933

38

## CERTIFICATE OF DEATH.

REGISTERED NO. E 18933

1-PLACE OF DEATH

City of BALTIMORE: (No. 1018 Low St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Dillon

(a) RESIDENCE NO. 1018 Low St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. dys. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: C

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of: John Dillon.

6 DATE OF BIRTH (month, day, and year): 1886

7 AGE — Years: 40 | Months: | Days: | IF LESS than 1 day.....hrs. or.....min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer:

9 BIRTHPLACE (city or town): Washington

(State or country): D.C.

PARENTS

10 NAME OF FATHER: Wilson Powell

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Washington D.C.

12 MAIDEN NAME OF MOTHER: Lucy Wright

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Unk

14 Informant: John Dillon

(Address): 1018 Low

Filed FEB 13 1927 T. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 5 1927 to Feb 11 1927

that I last saw h[illegible] alive on Feb 11 1927,

and that death occurred, on the date stated above, at 9:30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. * mos. 4 ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

Chronic Varicose Disease (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) [illegible], M. D.

Feb 12 1927 (Address) 5 E. Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cem. Date of Burial: 2/14 1927

20 UNDERTAKER: Bayne & Knight ADDRESS 1218 McCulloh

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

Dr. Noah

E 18934
1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

109-002

REGISTERED NO. E 18934

City of BALTIMORE: (No. 2412 Orleans St., 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julius Wm Freitag

(a) RESIDENCE NO 2412 Orleans St. 6 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. 7 mos. 5 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 17/22

| 7 AGE | Years | Months | Days |
|---|---|---|---|
| | 4 | 7 | 5 |

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): City

(State or country)

PARENTS

10 NAME OF FATHER Chas. C. Freitag

11 BIRTHPLACE OF FATHER (city or town): City

(State or country)

12 MAIDEN NAME OF MOTHER Anna Franz

13 BIRTHPLACE OF MOTHER (city or town): City

(State or country)

14 Informant Chas. C. Freitag

(Address) 2412 Orleans St

15 Filed ..... 19 .....

Registrar

Per .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/13/27

17 I HEREBY CERTIFY, That I attended deceased from Feb 7 19 27, to Feb 13 19 27, that I last saw him alive on Feb 13 19 27, and that death occurred, on the date stated above, at 8:35 A. m.

The CAUSE OF DEATH* was as follows:

Peritonsillar abscess

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Septicemia

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? abscess opened Date of Feb 9-1927

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Edward Novak, M. D.

, 19 (Address) 1211 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon PK — Date of Burial 2/14 1927

20 UNDERTAKER: Philip Herwig — ADDRESS 2016 Orleans

Very important. See instructions on back of certificates.

FEB 13 1927 C. HARRISON JONES, M. D.

Spec—12-23-21—E.B.R.S.—400 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18935 E 18935

## CERTIFICATE OF DEATH.

Registered No. 28-163

1-PLACE OF DEATH

City of BALTIMORE: (No. 4806 Liberty Heights Ave St., ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Sarah Smith Alt

(a) Residence No. 4806 Liberty Heights Ave St., ..... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-~~Single~~, Married, ~~Widowed, or Divorced~~. (Write the word.) Married

5a-If married, ~~widowed, or divorced~~, HUSBAND ~~of~~ or) WIFE of Casper Alt

6-DATE OF BIRTH (month, day and year) Jan. 9-1858

7-AGE. 69 yrs. 1 mos. 2 ds.

If LESS than 1 day, .... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country). Grand Island Nebr.

PARENTS.

10-NAME OF FATHER. Conrad Smith

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Marie A. Ulrick

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Casper Alt

(Address) 4806 Liberty Heights Ave.

15- FEB 13 1927 H. HAMPTON JONES, M. D. Registrar.

Per .....

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 11 - 1927

17- I HEREBY CERTIFY, That I attended deceased from Feb. 6 - , 1927, to Feb. 11 - , 1927, that I last saw her alive on Feb. 11 - , 1927, and that death occurred, on the date stated above, at 10.20 P. m.

The CAUSE OF DEATH* was as follows:

Cerebro-Vascular

(Duration) 10 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Myocardial Degen.

(Duration) 1 yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) C. K. Clausing, M. D.

2/12, 1927 (Address) 1120 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Woodlawn Cem. DATE OF BURIAL. Feb 14, 1927

UNDERTAKER. Wm. H. Valentine ADDRESS 2226 Aiken St

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18936

E 18936

## CERTIFICATE OF DEATH.

Hamilton-9/-002

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Dolton near Glenmont Ave WARD 43

2-FULL NAME James S. Fopless

(a) RESIDENCE NO. Dolton near Glenmont Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Eliza R Fopless

6 DATE OF BIRTH (month, day, and year): Feby 25 1848

7 AGE: Years 78 Months 11 Days 16 17 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Scroll Lawyer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 014

9 BIRTHPLACE (city or town) (State or country): Baltimore.

PARENTS

10 NAME OF FATHER: John Fopless

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Dont Know

14 Informant: Mrs Wm Dietrich

(Address): 5 Glenmont Ave

15 Filed [illegible] 19 [illegible] Registrar

Per

FEB 13 1927 C. HAMPSON JONES, M. D.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 - 1927 to Feb 11 1927

that I last saw him alive on Feb 10 1927

and that death occurred, on the date stated above, at 6 45 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

CONTRIBUTORY (Secondary): Hemiplegia (duration) yrs. mos. ds.

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis?

Signed: J C Hades M. D.

12/14/27 (Address) 1406 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem

DATE OF BURIAL: Feby 14 27

20 UNDERTAKER: John Allies

ADDRESS: 20 Eden

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18937

## CERTIFICATE OF DEATH.

100-001

REGISTERED NO. E 18937

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3300 O'Donnell ST. 76-1 WARD)

2-FULL NAME Charles F. Berkenkemper

(a) RESIDENCE No. 3300 O'Donnell ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catharine E.

6 DATE OF BIRTH (month, day, and year) Oct 28, 1889

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 37 | 3 | 15 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Fred. Berkenkemper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Cath. Mouth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto., Md.

14 Informant Catharine E. Berkenkemper (Address) 3300 O'Donnell St.

15 FEB 13 1927 19 C. HAMPSON JONES, M. D. Per K.H. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 11, 1927, to Feb. 12, 1927, that I last saw h[illegible] alive on Feb. 12 1927 and that death occurred, on the date stated above, at 12 20 P. m.

THE CAUSE OF DEATH was as follows:

Double Bronchio-Pneumonia

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) Acute Alcoholism

(duration) — yrs. — mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. E. McMahon M. D.

Feb. 13 1927 (Address) 3505 Frank Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Paul's Cemetery

DATE OF BURIAL Feb. 15 1927

20 UNDERTAKER Jirkler + Jirkler

ADDRESS 1739 E. Eager St.

THIS IS very important. See instructions on back of certificate.

Cor.—12-9-26—A Co.—200 Blks.

Neils P Clausen

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18938

CERTIFICATE OF DEATH.

92

E 18938

REGISTERED NO.

1-PLACE OF DEATH Maxwell - Frisk Ave.

City of BALTIMORE: (No.) Grape Road St. 16-37 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Neils P. Clausen

(a) RESIDENCE NO. 138 Maxwell Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 42 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma Clausen

6 DATE OF BIRTH (month, day, and year): March 25 1855

7 AGE: Years 71 Months 10 Days 14 16

IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired 62

(b) General nature of industry, business, or establishment in which employed (or employer): Watchman

(c) Name of employer: Nat. Cast. Co

9 BIRTHPLACE (city or town)

(State or country): Denmark

PARENTS

10 NAME OF FATHER: Simon Clausen

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Denmark

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Denmark

14 Informant: Catherine Ziegler

(Address): 138 Maxwell ave

15 Filed FEB 13 1927 17 Reg. No.

C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 11 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to h.s death on the day stated above.

The CAUSE OF DEATH* was as follows:

Thrombus Coronary

(duration) yrs. Smolder mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 2 yrs. mos. ds.

(Signed) James H Gilton M. D.

(Coroner)

2 11, 1927 (Address) 700 Clay St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cemetery Date of Burial: Feb 14 1927

20 UNDERTAKER: Zickler & Zickler ADDRESS: 1739 E. Eager St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

E 18939

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

100-001

E 18939
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home + Infirmary 7-12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Frank Hacker

(a) RESIDENCE NO. 946 Collington ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Eva Hacker

6 DATE OF BIRTH (month, day, and year): Jan. 18- 1869

7 AGE — Years: 58 — Months: " — Days: 24 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Polisher

(b) General nature of industry, business, or establishment in which employed (or employer): Brass

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Hungary

PARENTS

10 NAME OF FATHER: Don't know

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Don't know

12 MAIDEN NAME OF MOTHER: Don't know

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Don't know

14 Informant: August R. Hacker

(Address): 946 N. Collington ave

Filed FEB 13 1927 19 HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 11 19 27

17

I HEREBY CERTIFY, That I attended deceased from Feb 9, 1927, to Feb 11, 1927, that I last saw him alive on Feb 10, 1927, and that death occurred, on the date stated above, at 7.58 m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) .....yrs. .....mos. 2 ds.

CONTRIBUTORY (Secondary): Pulmonary abscess

(duration) .....yrs. .....mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Feb 9 27

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Abram Freed, M. D.

, 19 (Address) 1010 St Paul st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oakhill Cemetery — Date of Burial: Feb 14 1927

20 UNDERTAKER: Zirkler + Zirkler — ADDRESS: 1439 E. Eager st.

Fill in plain writing, and sign in ink. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

E 18940

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18940

## CERTIFICATE OF DEATH.

74-002

REGISTERED NO.

1-PLACE OF DEATH Eutaw - Laurale

CITY OF BALTIMORE: (No. Balto. Eye, Ear & Throat Hosp. ST. 1-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John D. Maskell

(a) RESIDENCE. No. 905 S. Curley ST.. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Maskell

6 DATE OF BIRTH (month, day, and year) Aug. 15 - 1869

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 57 | 5 | 28 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Orderly

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Hebrew Hospital

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Joseph Maskell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md

12 MAIDEN NAME OF MOTHER don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) don't know

14 Informant Jacob J. Maskell (Address) 905 S. Curley St

15 Filed FEB 13 1927 19 E. HAMPTON JONES, M. D. Registrar

By K H

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 3 1927 to Feb 12 1927, that I last saw him alive on Feb 12 1927, and that death occurred, on the date stated above, at 2.25 A. m.

The CAUSE OF DEATH* was as follows:

Chronic mastoiditis (duration 7 weeks)
Lateral Sinus thrombosis

(duration) yrs. mos. 7(?) ds.

CONTRIBUTORY (Secondary) Septicemia and metastatic abscess of knee(rt) (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of 2/4/27 & 2/10/27

Was there an autopsy? no.

What test confirmed diagnosis? Findings at operation

(Signed) Mary Louise Small, M. D.

2/12, 1927 (Address) 1214 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Sacred Heart Cem | Feb 15 1927 |
| 20 UNDERTAKER Zirkler & Zirkler | ADDRESS 1739 E. Eager St. |

TION is very important. See instructions on back of certificates.

Spec.—7-17-26—4 Co.—200 Bks.

E 18941

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

129

E 18941

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 105 N. Montford Ave St., 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard. Holzhaus.

(a) RESIDENCE NO. 105 N. Montford Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S. if of foreign birth 40 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married. |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Holzhaus.

6 DATE OF BIRTH (month, day, and year) Aug. 20-1853

| 7 AGE | Years | Months | Days | IF LESS than 1 day ...hrs. or ...min.. |
|---|---|---|---|---|
| | 74 | 5 | 21 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar maker.

(b) General nature of industry, business, or establishment in which employed (or employer) Wm. Boucher.

(c) Name of employer & Co. 07

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER John Holzhaus.

11 BIRTHPLACE OF FATHER (City or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Eva Eliz. Holzhaus. (Wife.)

(Address) 105 N. Montford Ave.

15 Filed ... 19 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 10-1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 31, 1927, to February 10, 1927.

That I last saw him alive on Feb. 10, 1927.

and that death occurred, on the date stated above, at 11.10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Arterial Hypertension

Chronic Interstitial Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis Arteriosclerosis

Pulmonary Edema

(duration) yrs. 1 mos. 10 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. L. Geyer M. D.

19 (Address) 156 N. Milton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. Date of Burial Feb. 14th 1927

20 UNDERTAKER Lilly and Zeiler ADDRESS 403 S. Wolfe St.

FEB 13 1927

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18942

## CERTIFICATE OF DEATH.

62

REGISTERED No. E 18942

1-PLACE OF DEATH

City of BALTIMORE: (No. 235 W Preston St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Burns

(a) RESIDENCE No. 235 W Preston St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Col | |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 26 1923

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 1 | 2 | 14 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto

PARENTS

10 NAME OF FATHER George Burns

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto

12 MAIDEN NAME OF MOTHER Martha Nicklos

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto

14 Informant George Burns

(Address) 235 W. Preston

15 Filed FEB 13 1927 19 C. HAMPTON JONES, M. D.

Per Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 10 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Enlarged Thymus

(Duration) yrs. 14 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. 1 ds.

(Signed) J C Stadler M. D.

(Coroner)

12/27 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Leakey Cem Feb. 13 1927

20 UNDERTAKER ADDRESS

Turd & Socks 1312 Jefferson

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18943

## CERTIFICATE OF DEATH. 181-001

E 18943

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1242 Battery Ave (ST.) 24-33 (WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth R F Rowe

(a) RESIDENCE NO. 1242 Battery ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Late Dr Robert S Rowe

6 DATE OF BIRTH (month, day, and year) Oct 25th 1855

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 71 | 3 | 13 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cambridge Md

PARENTS

10 NAME OF FATHER Noah Abbott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Fredericksburg Va

12 MAIDEN NAME OF MOTHER Elizabeth R F Abbott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cambridge Md

14 Informant Robert Edward Rowe
(Address) 1242 Battery Ave

15 Filed FEB 13 1927 C. HARRISON JONES, M. D. Registrar
By R M

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 10 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 8 1927 to Feb 10 1927.
that I last saw him alive on Feb 10 1927.
and that death occurred, on the date stated above, at 7 45 P m.

The CAUSE OF DEATH* was as follows:
From the effects of apoplexy
Accidental
Illuminating Gas
Myocardial Insufficiency
(duration) yrs mos ds.

CONTRIBUTORY (Secondary) old age
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C Harrison, M. D.
19 (Address) 1215 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
Loudon Park

DATE OF BURIAL
Feb 14th 1927

UNDERTAKER
Frank V. Pikitora

ADDRESS
2818 E. Balt

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100.001 E 18944

## CERTIFICATE OF DEATH.

E 18944

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 2509 Hollins ST. 20-69 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Lacy Fisher Jr.

(a) RESIDENCE No. 2509 Hollins ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 10 1926

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | | 5 | 2 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER James L. Fisher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Josephine Lang

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant James L. Fisher

(Address) 2509 Hollins

15 Filed FEB 13 1927 C. HAMPSON JONES, M. D. Registrar

per Dyk.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1926, to Feb 12, 1927, that I last saw him alive on Feb. 12, 1927, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Marasmus

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Findings

(Signed) John A Brachmeus M. D.

, 19 (Address) 375 Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery

DATE OF BURIAL: Feb 14 1927

20 UNDERTAKER: H. Howard Evans

ADDRESS: 2 E Fortay

TION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

E 18945

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

74-001

E 18945

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1171 Cleveland ST., 21st WARD 29

2-FULL NAME Charles B Eichorn

(a) RESIDENCE NO. 1171 Cleveland ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or ~~WIFE of~~): Barbara Eichorn

6 DATE OF BIRTH (month, day, and year): June 18-1855

7 AGE: Years 71; Months 8; Days 18; If LESS than 1 day, ..... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: John Eichorn

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dorothea

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Barbara Eichorn 1171 Cleveland st

Filed FEB 13 1927 C. HAMPSON JONES, M. D. Registrar

By: R H

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2-11-27

17 I HEREBY CERTIFY, That I attended deceased from 1-1, 1927 to 2-11, 1927.

that I last saw h alive on 2-11, 1927

and that death occurred, on the date stated above, at 3 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Alfred Dunn M. D.

, 19 (Address) 117 North Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon P K Cemetery

DATE OF BURIAL: 2/14/27

20 UNDERTAKER: Geo Leimbach & Son

ADDRESS: C42W Pratt St

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 18946 HEALTH DEPARTMENT—CITY OF BALTIMORE E 18946

CERTIFICATE OF DEATH. 89

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1631 Druid Hill ave ST.) 14-20 (WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bradley Garner

(a) RESIDENCE. No. 1631 Druid Hill ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | Colored | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Capitola Garner

6 DATE OF BIRTH (month, day, and year) Nov 26-1876

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 50 | 1 | 15 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labourer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER George Garner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Susan Dorsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Capitola Garner (Address) 1631 Druid Hill ave

15 Filed OCT 3 1927 19 HAMPSON JONES, M. D., Registrar

Per RR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 1927 to July 11 1927.

that I last saw h. alive on July 9 1927.

and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Angina pectoris

(duration) — yrs. 1 mos. 15 ds.

CONTRIBUTORY (Secondary) Coronary arteriosclerosis

(duration) — yrs. 2 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Medical

(Signed) Chas. Keller M. D.

July 19 27 (Address) 222 W. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Bush Park - Howard Co. Md. | 7/10/27 |

| 20 UNDERTAKER | ADDRESS |
|---|---|
| Mrs. Geo. A. Holland | 1631 Druid Hill |

TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 18947 — 1-PLACE OF DEATH

31 E 18947 — REGISTERED NO.

City of BALTIMORE: (No. Baltimore City Hospitals St., 6-9 (B.) Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Malone

(a) RESIDENCE NO. 319 N. Bond st. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1862

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 65 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Lawrence Malone

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Kate McCaffey

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

Informant Hospital Records

(Address)

Date Filed FEB 13 1927

G. HAMPSON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 10, 1927

17

I HEREBY CERTIFY, That I attended deceased from January 10, 1927 to February 10, 1927, that I last saw him alive on February 10, 1927, and that death occurred, on the date stated above, at 7.30 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) W. E. Baker, M. D.

2-11-27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Sacred Heart Cem 2/13 1927

20 UNDERTAKER — ADDRESS

P. F. Tabby Sons 1316 Light St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 18948

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 E 18948

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1460 William ST., 24-34 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Walters

(a) RESIDENCE NO. 1460 William ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. 11 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | white | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alvin E. Walters

6 DATE OF BIRTH (month, day, and year) Feb. 28 190[illegible]

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 24 | 11 | 12 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Wm F. Southern

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Annie P. Knotts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs Southern (Address) 1460 William

15 Filed [illegible], 19 [illegible] Registrar

C. HAMPSON JONES, M. D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-10 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 27, 1926, to Feb 10, 1927, that I last saw her alive on Feb 9, 1927 and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted — If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) C. H. Hampson Jones, M. D.

2/11, 1927 (Address) 6 E Cardall

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London P K Cem

DATE OF BURIAL 2/14 1927

20 UNDERTAKER D. Frew McCully

ADDRESS 130 E Fort

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18949

## CERTIFICATE OF DEATH.

129 E 18949

1-PLACE OF DEATH

REGISTERED NO. 23-34

CITY OF BALTIMORE: (No. 1617 Patapsco ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William A. Hutton

(a) RESIDENCE NO. 1617 Patapsco ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. 9 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | white | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillie K. Hutton

6 DATE OF BIRTH (month, day, and year) May 9-1869

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min |
|---|---|---|---|---|
| | 57 | 9 | 2 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer Odd

(b) General nature of industry, business, or establishment in which employed (or employer) City of Balto

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER James Hutton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Mary A. Remsberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs Hutton (Address) 1617 Patapsco

15 Filed FEB 13 1927 T. HAMPSON JONES, M. D. Registrar

Per L K

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 8, 1927 to Feb. 11 1927.

that I last saw him alive on Feb 10 1927

and that death occurred, on the date stated above, at 5 A M

The CAUSE OF DEATH* was as follows:

Uraemic Coma

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic nephritis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Thurlow Lamb, M. D.

(Address) 1 Randall Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem

DATE OF BURIAL 2/14 1927

20 UNDERTAKER J. Fenwick McCally

ADDRESS 130 E. Fort

TION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

100-001 E 18950

E 18950

1. PLACE OF DEATH

CITY OF BALTIMORE. (No. 673 E. Clement St. 24-33 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Mc Evoy

(a) RESIDENCE NO. 673 E. Clement ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. 7 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | white | Widower |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E Mc Evoy

6 DATE OF BIRTH (month, day, and year) July 4 - 1847

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 79 | 7 | 8 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Wm. Mc Evoy

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Mrs. Woods 673 E. Clement

15 Filed 8 13 1927 19 Per C. HAMPTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-12 1927.

17 I HEREBY CERTIFY, That I attended deceased from 4.2.1918, 19, to 2.12.27, 19,

that I last saw h in alive on 2.12.27, 19,

and that death occurred, on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) ~~Chronic~~ Arteriosclerosis 8

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical only

(Signed) Philip B. Fowler, M. D.

2.12.27 (Address) 1432 William St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL 2/15 1927

20 UNDERTAKER J. Frew Mc Cully — ADDRESS 130 E. Fort

TION is very important See instructions on back of certificate.

Spec. 1-10 21 M&T 1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18951

## CERTIFICATE OF DEATH.

43

E 18951

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1302 W. Lexington ST. 14-Na WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles J. Weber

(a) RESIDENCE No. 1302 W. Lexington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna B. Moser Weber

6 DATE OF BIRTH (month, day, and year) March 7 1859

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| 67 | 68. | 11 | 4 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 086

(b) General nature of industry, business, or establishment in which employed (or employer) B & O. Machine

(c) Name of employer Shop.

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Jacob Weber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Cephalonia Graff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mrs. Anna B. M. Weber

(Address) 1302 W Lexington St

15 Filed 3 13 1927 C. HAMPSON JONES, M. D.

Per Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 11 1927.

17 I HEREBY CERTIFY, That I attended deceased from Jany 10, 1927, to Feb 11, 1927, that I last saw h alive on Feb 11, 1927, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows: Carcinoma Ileo-Cæcal - 14 ds.

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Anemia

(duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes. Date of Feb 4 1927

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) [illegible], M. D.

7/12 1927 (Address) Hilton Co.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge — DATE OF BURIAL Feby 14 1927

20 UNDERTAKER John O. Mitchell — ADDRESS 1905 Eutaw Place

CAUSE OF DEATH must be plainly written, so that it may be properly classified. Each question must be answered if possible. TION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E18952 3-2

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

+74002

REGISTERED NO. E 18952

1-PLACE OF DEATH University Hospital

City of BALTIMORE: (No. 4-30 St. ..... Ward .....)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Hopf

(a) RESIDENCE NO. Columbia Pike-Ellicott City St. ..... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 2 ds. How long in U. S. if of foreign birth? ..... yrs. ..... mos. ..... ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) June 21, 1877

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|---|
| | 49 | 7 | 23 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) .....

(State or country) Germany

PARENTS

10 NAME OF FATHER August Hopf

11 BIRTHPLACE OF FATHER (City or town) .....

(State or country) Germany

12 MAIDEN NAME OF MOTHER Matilda Lang

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) Germany

14 Informant Husband

(Address) .....

15 Filed FEB 14 1927, 19 C. HAMPSON JONES, M. D. Registrar

Per RK

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/13/27 19

17 I HEREBY CERTIFY, That I attended deceased from 2/11/27, 19..., to 2/13/27, 19..., that I last saw her alive on 2/12/27, 19..., and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism
(Death occurred suddenly)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cholecystitis
Cholelithiasis
Jaundice (duration) ..... yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of 2/12/27 Was there an autopsy? no

What test confirmed diagnosis? operation

(Signed) J. S. Whitehead, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Forest Ridge Cem. | Feb 16 1927 |
| 20 UNDERTAKER | ADDRESS |
| Easton Sons | Ellicott City |

(If any amount is missing, illegible, or incorrect, the certificate may be returned for correction. Exact statement of OCCUPATION is very important. See instructions on back of certificates.)

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18953

## CERTIFICATE OF DEATH.

90 E 18953

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 818 Pierce ST. 17-26 WARD)

2-FULL NAME Martha Scott

(a) RESIDENCE NO. 818 Pierce ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fem

4 COLOR OR RACE Col'd

5 Single, Married, Widowed, or Divorced, (write the word) Wid

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1861

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min |
|---|---|---|---|---|
| | 65 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) Balto City Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Lucien Scott

(Address) 818 Pierce

FEB 14 1927 C. HAMPSON JONES, M. D. Registrar

Per RR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 12 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 4 1927, to Feb 12 1927, that I last saw h alive on Feb 12 1927 and that death occurred, on the date stated above, at 11 A m

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(duration) Uncertain yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Debility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis?

(Signed) P A Bovenel, M. D.

, 19 (Address) 95 N Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Mt Auburn Cem | Feb 14 1927 |
| 20 UNDERTAKER Edward Eastern | ADDRESS 514 |

TION is very important See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18954

## CERTIFICATE OF DEATH.

90

E 18954

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St., 11-24 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Mitchell

(a) RESIDENCE NO. 1118 Jenkins Alley St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Negro | Widowed |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1865

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 62 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Georgia

PARENTS

10 NAME OF FATHER Robert Green

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Georgia

12 MAIDEN NAME OF MOTHER Emma —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Georgia

14 Informant BALTIMORE CITY HOSPITALS

(Address) Records

15 Filed FEB 14 1927 C. HAMILTON JONES, M. D.

Per RK Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 10 1927

17

I HEREBY CERTIFY, That I attended deceased from January 27, 1927, to February 10, 1927, that I last saw h[illegible] alive on February 10, 1927, and that death occurred, on the date stated above, at 5:40 P m.

The CAUSE OF DEATH* was as follows:

Arterial Sclerosis

Chronic Myocarditis & Incomplete

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Gensual & Laboratory

(Signed) R. Hooper Smith, M. D.

Feb 12 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Mt Auburn Cem Feb 14 1927

20 UNDERTAKER ADDRESS

Wm E Easton 60 Alt

Cy DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18955

## CERTIFICATE OF DEATH.

185 E 18955

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home & Infirmary St., 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Amelia Fischer

(a) RESIDENCE NO. 1637 N. Bond St St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| female | white | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Carl Fischer

6 DATE OF BIRTH (month, day, and year) March 26/1850

| 7 AGE 76 | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 77 | 9/0 | 16 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Wm Ellenberger

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Ercha[illegible]

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Martha Fennert

(Address) 1719 Green Ave, Brooklyn

Filed FEB 14 1927 C. Hampson Jones M. D. Registrar

Per RK

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Terminal Pneumonia

Fracture of Rt. femur- Accidently fell in bed room Feb 7/27

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

(duration) .....yrs. .....mos. .....ds.

(Signed) J. H. Pollitz M. D. (Coroner)

2/12/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Balto Cemetery | Feb 14 1927 |

20 UNDERTAKER Robt J. Turner & Son ADDRESS 1447 N. Broadway

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 18956

## CERTIFICATE OF DEATH.

E 18956

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1814 Michelson St., 14-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Milton Clarke

(a) RESIDENCE NO. 1814 Michelson St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 9 1873

7 AGE: Years 53 Months 7 Days 2

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter

(b) General nature of industry, business, or establishment in which employed (or employer): 05

(c) Name of employer

9 BIRTHPLACE (city or town): Pa

(State or country)

PARENTS

10 NAME OF FATHER: Joseph M. Clarke Sr

11 BIRTHPLACE OF FATHER (city or town): Unknown

(State or country)

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): Unknown

(State or country)

14 Informant: Theodora Mae Clarke

(Address) 1814 Michelson St

15 Filed ..... 19 .....

Registrar

FEB 14 1927 C. HAMPSON JONES, M. D.

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Mitral Regurgitation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Thos B Norton M. D.

(Coroner)

Feb 13 1927 (Address) Curtis Bay, Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore — Date of Burial: Feb 14 1927

20 UNDERTAKER: H. Cook — ADDRESS: 307 E Baltimore

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18957

## CERTIFICATE OF DEATH.

167-801

E 18957

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 316 Guilford Ave 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter F. Macneal

(a) RESIDENCE NO. 1631 N. Broadway St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Isabelle Macneal

8 DATE OF BIRTH (month, day, and year): Aug - 13 - 1871

7 AGE: Years 55 Months 5 Days 28 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Grain Ford

(b) General nature of industry, business, or establishment in which employed (or employer): Merchant

(c) Name of employer: Self

9 BIRTHPLACE (city or town): Baltimor

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Philip D Macneal

11 BIRTHPLACE OF FATHER (city or town): Baltimor

(State or country): Maryland

12 MAIDEN NAME OF MOTHER: Isabelle England

13 BIRTHPLACE OF MOTHER (city or town): Baltimor

(State or country): Maryland

14 Informant: W. Vernon Macneal

(Address) 2316 Rosedale St

Filed: FEB 14 1927 19 .....

Registrar: R K

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): February 16th 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Illuminating Gas (duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

(duration) .....yrs. .....mos. .....ds.

(Signed) H. Nichols M. D.

(Coroner)

Feb 17, 1927 (Address) 1639 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loraine Cemetery Date of Burial 2/16 1927

20 UNDERTAKER: William Cook ADDRESS 502 E North Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 18958

## CERTIFICATE OF DEATH.

REGISTERED NO. E 18958

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hosp St., 7-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rita T Miller

(a) RESIDENCE NO. 5223 Chapel St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | W | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) 2-10-25

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 2 | | 2 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Joseph Tamosh

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balt

12 MAIDEN NAME OF MOTHER Mat Kuzava

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Mat Kuzava

14 Informant Joseph Tamosh

(Address) 1117 Hollyd

15 Filed FEB 14 1927 C. HAMPSON JONES, M. D. Registrar

Per R.H.

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/12 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intestinal Toxemia

Broncho Pneumonia

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) Samuel T Miller M. D.
(Coroner)

, 1927 (Address) 3325 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Hill Date of Burial Feb 14 1927

20 UNDERTAKER Frank Ewell & Son ADDRESS Feb 14 1927

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Pks.

E 18959

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31

E 18959

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 12 S Carlton St. 18-29 Ward)

2-FULL NAME Laura Burton

(a) RESIDENCE NO. 12 S Carlton St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): oct 18 1908

7 AGE: Years 18 | Months 4 | Days 20 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto

PARENTS

10 NAME OF FATHER Clifton Burton

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto

12 MAIDEN NAME OF MOTHER Mollie able

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto

14 Informant Clifton Burton

(Address) 12 S Carlton st

Filed FEB 14 1927, 19

C. HAMPSON JONES, M. D.

Registrar

Per K.K.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/12 1927

17 I HEREBY CERTIFY, That I attended deceased from 2/11/27, 19..., to 2/12/27, 19..., that I last saw h.... alive on 2/12/27, 19..., and that death occurred, on the date stated above, at 3:45 P. m.

The CAUSE OF DEATH* was as follows:

Pul Phthisis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis

History about 5 (duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death!

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Bernard J. Finy, M. D.

2/12/27 (Address) 910 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Peleo Date of Burial: Feb 15 1927

20 UNDERTAKER: John J Fulde ADDRESS: 1200 W Lombard

FEB 14 1927

For STATE REGISTRAR. NOTE.—Information required by law. All questions must be answered so far as known. Certificate of DEATH must be filed with Registrar of Vital Statistics before BURIAL or REMOVAL from city. Undertaker must obtain PERMIT for burial or removal before interment. Physician must report CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 18960

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

161-001 E 18960

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1113 Watson St. St. 3-5 Ward)

2-FULL NAME Baby Curtis

(a) RESIDENCE NO. 1113 Watson St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Black

5 Single, Married, Widowed, or Divorced, (write the word)

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2/12/27

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | | | | 3 |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER Richard Curtis

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Thomas

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant C. H. Peckham

(Address) Johns Hopkins Hospital

C. HAMILTON JONES, M. D.

15 Filed FEB 14 1927, 19 Per RJC Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/12/27 19

17 I HEREBY CERTIFY, That I attended deceased from 2/12/27, 19, to 2/12/27, 19,

that I last saw ~~him~~ ~~she~~ on Premature 2/12/27, 19,

and that death occurred, on the date stated above, at 5:00 A m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. H. Peckham, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury — Date of Burial: Feb 19 1927

20 UNDERTAKER: John W. Henderson — ADDRESS 1502 E. Monument

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 18961

## CERTIFICATE OF DEATH

REGISTERED NO. E 18961

1-PLACE OF DEATH

City of BALTIMORE: (No. 726 N. Spring St., 7-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lana White

(a) RESIDENCE NO. 726 N. Spring St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Colored | widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow

6 DATE OF BIRTH (month, day, and year) Unknown 1879

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min.. |
|---|---|---|---|---|
| 45 47 | | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) St. Marys Co.

(State or country) Md.

PARENTS

10 NAME OF FATHER John Bords

11 BIRTHPLACE OF FATHER (City or town) St. Marys Co.

(State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Cora Williams

(Address) 1437 N. Hill St. Phila Pa

15 Filed ..... 19 ..... Registrar

FEB 4 1927 C. HAMPSON JONES, M. D.

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 7 1927 to Feb 11 1927

that I last saw h alive on Feb 10 1927

and that death occurred, on the date stated above, at 8:30 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W Clyde Burns M. D.

. 19 (Address) 2017 E. 32

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Valley Lee St. Marys Co. Md. | Feb 14 1927 |
| 20 UNDERTAKER | ADDRESS |
| Chris. H. Johnson | 1672 N. Carolina St. |

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

9:15 am

# HEALTH DEPARTMENT—CITY OF BALTIMORE

91-003

**E 18962**

## CERTIFICATE OF DEATH.

**E 18962**

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 307 N. Exeter St., 5-8 Ward)

2-FULL NAME Josephine Re

(a) RESIDENCE NO. 307 N. Exeter St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Femal

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Widowed

3a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mariano Re

6 DATE OF BIRTH (month, day, and year): July 7th 1853

7 AGE: 73 Years 7 Months 5 Days. IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: H. W. 37

(b) General nature of industry, business, or establishment in which employed (or employer): — — —

(c) Name of employer

9 BIRTHPLACE (city or town): Italy

(State or country)

PARENTS

10 NAME OF FATHER Unknow

11 BIRTHPLACE OF FATHER (city or town): Italy

(State or country)

12 MAIDEN NAME OF MOTHER Vincenza unknow

13 BIRTHPLACE OF MOTHER (city or town): Italy

(State or country)

14 Informant: Michele Re

(Address) 307 N. Exeter St.

15 Filed ..... 19..... C. HAMPSON JONES, M. D.

Registrar

FEB 14 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/12 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec. 2 1926, to Feb. 11, 1927, that I last saw h alive on Feb. 11, 1927, and that death occurred, on the date stated above, at 9.15 a. m.

The CAUSE OF DEATH* was as follows:

Gangrene

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Endarteritis Obliterans

(duration) yrs. 3 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? symptoms

(Signed) A. Palumbiano, M. D.

2-12, 1927 (Address) 145 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery Date of Burial 2/14 1927

20 UNDERTAKER: Geo J. Ruth ADDRESS 1735 Harford ave

tion should be carefully supplied. AGE should be stated EXACTLY. If infant, state hours, days or months. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 18963

## CERTIFICATE OF DEATH.

E 18963

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 12-50 Ward)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrollyn Bull

(a) RESIDENCE NO 3021 N. Calvert St St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 8 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): June 5 1921

7 AGE: XX Years 5 Months 8 Days 7 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town): Balto

(State or country): Md

PARENTS

10 NAME OF FATHER: Carroll Bull

11 BIRTHPLACE OF FATHER (city or town): —

(State or country): Tenn

12 MAIDEN NAME OF MOTHER: Selma Smith

13 BIRTHPLACE OF MOTHER (city or town): —

(State or country): Ga

14 Informant: Records

(Address): JOHNS HOPKINS HOSP

15 Filed FEB 14 1927 C. HAMPSON JONES, M.D. Registrar

Per _____

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 12 1927

17 I HEREBY CERTIFY, That I attended deceased from 5 Feb. 1927 to 12 Feb. 1927, that I last saw h[er] alive on 12 Feb. 1927, and that death occurred, on the date stated above, at 6 [illegible] p.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) .....yrs. .....mos. 7 ds.

CONTRIBITORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted if not at place of death? 3021 N. Calvert St.

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) M E L Handley, M. D.

2/12, 1927 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem. Date of Burial Feb 14 1927

20 UNDERTAKER: Wm J Tucker Sons ADDRESS Norfolk Va

Don't should be carefully supplied. Age should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18964

## CERTIFICATE OF DEATH.

E 18964

REGISTERED NO. 76-77

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital St., (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Erma N. Meyer.

(a) RESIDENCE NO. 1705 Pennington Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs 5 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

9a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 15, 1926

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 0 | 5 | 28 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER John P. Meyers

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Natalie Gollin

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant John P. Meyers (Address) 1705 Pennington Ave

15 Filed FEB 14 1927 By R. H. HAMILTON JOHNS, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 12 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb 11, 1927, to Feb 12, 1927, that I last saw h[illegible] alive on Feb. 12, 1927 and that death occurred, on the date stated above, at 9 00 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lumbar puncture

(Signed) Myron G. Tull, M. D.

2/14, 1927 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem. DATE OF BURIAL Feb. 14 1927

20 UNDERTAKER Margaret J. Flynn ADDRESS 1422 Light St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of cause of death is very important. See instructions on back of certificates.

Spec.—12 9-25—1 Co.—200 Bks.

1927 18965

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18965

## CERTIFICATE OF DEATH.

33

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 15-22 Ward) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillie Claffett

(a) RESIDENCE NO. 1383 Wheeler St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 11 13 24

7 AGE: Years 2 | Months 2 | Days 27 12 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Evansville

(State or country) Ind.

PARENTS

10 NAME OF FATHER Samuel Claffett

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ind.

12 MAIDEN NAME OF MOTHER Anna Young

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va.

14

Informant Reynolds

(Address) JOHNS HOPKINS HOSPITAL

Filed FEB 14 1927 G. HAMPSON JONES, M. D. Registrar

per

### MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH (month, day, and year) Feb 12 1927

17

I HEREBY CERTIFY, That I attended deceased from Dec 28, 1926, to Feb 12, 1927, that I last saw h alive on Feb 12, 1927, and that death occurred, on the date stated above, at 9:30 a m.

The CAUSE OF DEATH* was as follows:

Tuberculous peritonitis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Mediastinal Tuberculosis

(duration) yrs. 5 mos. ds.

18 Where was disease contracted

If not at place of death? 1383 Wheeler St

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. E. Handley, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem. Date of Burial: Feb 14 1927

20 UNDERTAKER: Vandiver & Son ADDRESS: 946 E

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18966

## CERTIFICATE OF DEATH

2863 124

REGISTERED NO. E 18966

1-PLACE OF DEATH

City of BALTIMORE: (No. 4207 Belview Ave St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jesse N. Hamilton.

(a) RESIDENCE NO. 4207 Belview Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. — mos. — ds. How long in U. S. if of foreign birth? yrs. mos. ds.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Bertha Hamilton

6 DATE OF BIRTH (month, day, and year): September 30. 1873

7 AGE: Years 53 Months 4 Days 13

IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Special Representative

(b) General nature of industry, business, or establishment in which employed (or employer): R.R.

(c) Name of employer B & O. R. R.

9 BIRTHPLACE (city or town)

(State or country) Cumberland Md

PARENTS

10 NAME OF FATHER James E. Hamilton

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Cumberland Md

12 MAIDEN NAME OF MOTHER Catherine Herbst

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Not Known

14 Informant Bertha Hamilton

(Address) 4207 Belview Ave

15 Filed ... 19 ... Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) FEB 13 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Jan 17, 1927, to Feb 13, 1927,

that I last saw him alive on Feb 2, 1927,

and that death occurred, on the date stated above, at 7 15 A m.

The CAUSE OF DEATH* was as follows:

Obstruction Cholangitis

(duration) yrs. 4 mos. 8 da.

CONTRIBUTORY (Secondary) Obstruction Cholangitis

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of Sept 24-1926

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) , M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cumberland Md — Date of Burial: FEB 15 1927 19

20 UNDERTAKER: Geo W Little — ADDRESS

FEB 14 1927 C. HAMPSON

Spec.—7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

172-002

E 18967

REGISTERED NO. E 18967

1-PLACE OF DEATH

City of BALTIMORE: (No.) 2936 Cedar Ave. St. (Ward) 13-51

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James J. Harrison

(a) RESIDENCE NO. 2936 Ceda Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 ~~Single, Married,~~ Widowed, or ~~Divorced~~, (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~: Ella A. Harrison

6 DATE OF BIRTH (month, day, and year): April 1, 1868.

7 AGE: Years 58 69 | Months 10 | Days 11 | IF LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town): Va

(State or country)

PARENTS

10 NAME OF FATHER: William H. Harrison

11 BIRTHPLACE OF FATHER (City or town): Va.

(State or country)

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): Unknown

(State or country)

14 Informant: Ella A Harrison

(Address) 2936 Cedar Ave.

15 Filed FEB 14 1927 C. HAMPSON JONES, M. D. Registrar

Per R M

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: Dec 12 27

17 I HEREBY CERTIFY, That I attended deceased from Jan 19, 1927, to Dec 12, 1927, that I last saw him alive on Dec 12, 1927, and that death occurred, on the date stated above, at 7.10 a m.

The CAUSE OF DEATH* was as follows:

(a) Cardiac Failure

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Cardiac Sclerosis Prostatic Obstruction

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. E. Richardson, M. D.

Dec 12, 1927 (Address) 1760 Mt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Hampden — Date of Burial: Feb 14 27

20 UNDERTAKER: Chenowith Son — ADDRESS: 3617 Chestnut Ave

If not buried, cremated or removed within 24 hours, notify Health Department.

INSTRUCTIONS: This certificate, WITH ONE ENTRY ONLY—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18968

## CERTIFICATE OF DEATH.

E 18968

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5 Belvedere Ave ST., 27-54 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Earl B. Redmond Jr.

(a) RESIDENCE No. 5-Belvedere Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 20 1926

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs. or ....min. |
|---|---|---|---|---|
| | | 1 | 23 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Earl. B. Redmond Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER May. E. Pees

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cincinnati Ohio

14 Informant Earl. B. Redmond Jr (Address) 5 W. Belvedere Terrace

15 Filed ..., 192... Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 12 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Convulsions

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Hugh Morrison M. D. (Coroner.)

2-12-27, 192... (Address) 2632 Reisterstown Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemetery — DATE OF BURIAL: Feb 14 192 7

20 UNDERTAKER: Jos Joerdens Son — ADDRESS: 207 S. Pa...

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Andrew Scott

# HEALTH DEPARTMENT—CITY OF BALTIMORE

**E 18969**

## CERTIFICATE OF DEATH.

129

**E 18969**

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1518 Booth St. (ST.,) 19-28 (WARD)

2-FULL NAME Andrew Scott

(a) RESIDENCE NO. 1518 Booth ST., ..... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Husband

6 DATE OF BIRTH (month, day, and year): Dont Know

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| 79 | — | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Hostler

(b) General nature of industry, business, or establishment in which employed (or employer): stable

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): West River Md

PARENTS

10 NAME OF FATHER: Augustus Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country): West River Md

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): "

14 Informant: Georgiana Scott
(Address) 1508 Booth st

15 Filed ..... 19.. Registrar .....

G. HAMPDEN JONES, M. D.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 11 19 29

17 I HEREBY CERTIFY, That I attended deceased from Sept ..., 19.., to Feb 11, 19 29,

that I last saw h... alive on Feb 10, 19 29,

and that death occurred, on the date stated above, at 4:45 P.M.

The CAUSE OF DEATH* was as follows:

Chronic bronchitis

..... (duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) ..... M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: Feb 14th 1929

20 UNDERTAKER: A. Jones — ADDRESS: 111 S. Gilmor

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18970

## CERTIFICATE OF DEATH.

E 18970

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Baltimore Gen. Hosp. WARD) 10-14

REGISTERED NO. 45

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Milton Bowman

(a) RESIDENCE NO. 704 E Chase St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~1 year~~ single mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 4 1877

7 AGE: 49 Years 10 Months 25 Days 24 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Missouri

PARENTS

10 NAME OF FATHER: Moses Bowman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER: Belle Snyder

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: West Baltimore Gen Records (Address)

15 Filed FEB 14 1927 Registrar H. HAMPSON JONES, M. D.

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/12 1927

17 I HEREBY CERTIFY, That I attended deceased from 2/10, 1927, to 2/12, 1927, that I last saw him alive on 2/12, 1927, and that death occurred, on the date stated above, at 9 a.m. p.m.

The CAUSE OF DEATH* was as follows:

Primary Carcinoma of the ileum

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Intestinal Obstruction

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 2/11/27

Was there an autopsy? yes

What test confirmed diagnosis? Clinical & P.M. findings

(Signed) Charles L. Jensen, M. D.

2/12 1927 (Address) 1st Baptist Gen. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: Feb. 14 1927

20 UNDERTAKER: Joseph Dyer — ADDRESS: 1600 W North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. PHYSICIANS should state EXACTLY: Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 18971

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 18971

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 296 Southern Ave ST. 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John A. Pilsch

(a) RESIDENCE No. 296 E. Southern Ave. ST., Gardenville WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Betty Pilsch

6 DATE OF BIRTH (month, day, and year): Feb. 24th 1870

7 AGE — Years: 56 — Months: 11 — Days: 19 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Patrolman 061

(b) General nature of industry, business, or establishment in which employed (or employer): Balto. Police

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Jacob Pilsch

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Maryland

12 MAIDEN NAME OF MOTHER: Elizabeth Edmead

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown Unknown

14 Informant: Betty Pilsch (Address) 296 Southern Ave.

15 Filed FEB 14 1927 19 Per

C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 12 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 7, 1927, to Feb 12, 1927, that I last saw him alive on Feb 12, 1927, and that death occurred, on the date stated above, at 12:20 P.M.

The CAUSE OF DEATH* was as follows:

Acute Toxic Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Cirrhosis Kidneys

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature] M. D.

2/14, 1927 (Address) 4706 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery — DATE OF BURIAL: Feb. 15 1927

20 UNDERTAKER: Fredk. Bosse & Sons — ADDRESS: Fullerton

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

Leo N Hardesty, Garfield Group

E 18972

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

37-46 124

E 18972

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 420 Evesham Ave St. 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth G. Henderson

(a) RESIDENCE NO. 420 Evesham Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo N Henderson

6 DATE OF BIRTH (month, day, and year): Oct 11, 1869.

7 AGE: Years 57 Months 4 Days 2

IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: John G Cole

11 BIRTHPLACE OF FATHER (City or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Margaret Groh

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Geo N Henderson

(Address): 420 Evesham Ave

Filed FEB 14 1927, 19 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 13 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 20, 1927, to Feb 13, 1927,

that I last saw h[er] alive on Feb 13, 1927,

and that death occurred, on the date stated above, at 11.30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Colitis

(duration) yrs 1½ mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Robt N. Stockton M. D.

. 19 (Address) 5535 York Rd

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore

Date of Burial: Feb 16 1927

20 UNDERTAKER: Fallon Cook

ADDRESS: 502 Eastern Ave

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18973

90 E 18973

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St. 4-25 Ward)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Strauss

(a) RESIDENCE NO. 515 West Luxington St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elsie Straus

6 DATE OF BIRTH (month, day, and year): Oct 8 1887

7 AGE: 39 Years 40 Months 4 Days 5 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Builder 013

(b) General nature of industry, business, or establishment in which employed (or employer): Butcher

(c) Name of employer

9 BIRTHPLACE (city or town): Newark

(State or country): New Jersey.

PARENTS

10 NAME OF FATHER: Nathan Strauss

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Austria

12 MAIDEN NAME OF MOTHER: Rosie ~~Lehlanger~~

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Austria

14 Interment BALTIMORE CITY HOSPITALS

(Address) Rec'd [redacted]

15 Filed _____, 19 _____ Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): February 13 1927

17

I HEREBY CERTIFY, That I attended deceased from February 3, 1927, to February 13, 1927, that I last saw him alive on February 13, 1927, and that death occurred, on the date stated above, at 3 00 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Mitral Stenosis & Insufficiency

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. 6 mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? General & laboratory

(Signed) R. Hooper Smith, M. D.

Feb 13 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship Cem

Date of Burial 2/15/27 19

20 UNDERTAKER: Jack Levis

ADDRESS 1409 Eastern Ave

(Physician's or Undertaker's Copy)

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

THIS IS A PERMANENT RECORD.

Spec.—12-9-25—A Co.—200 Bks.

E 18974

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18974

## CERTIFICATE OF DEATH.

REGISTERED NO. 1561

1-PLACE OF DEATH Sinai Hospital

City of BALTIMORE: (No. Monument St., Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Sally Levy

(a) RESIDENCE NO. 3017 Powhatan Ave St. Ward 6.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? 37 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced (or) WIFE of: Simon Levy

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 67 — Months: — — Days: — — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ~~Russia~~ 37

(b) General nature of industry, business, or establishment in which employed (or employer): Housewife

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Russia

PARENTS

10 NAME OF FATHER: S. Glodsky

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Russia

14 Informant: S. Levy

(Address): Durham N C

FEB 14 1927

15 Filed ....., 19..... C. HAMPSON JONES, M. D.

Per ..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Feb. 13, 1927

17

I HEREBY CERTIFY, That I attended deceased from 2-12, 1927, to 2-13, 1927,

that I last saw h.. alive on 2-13, 1927,

and that death occurred, on the date stated above, at 4.10 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death? C

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) H Edmund Levin, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Durham N C — Date of Burial 2/14 1927

20 UNDERTAKER: Jack Lewis — ADDRESS 1439 E Balto St

THIS CERTIFICATE SHOULD BE CAREFULLY PREPARED, WRITTEN IN PERMANENT BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18975

## CERTIFICATE OF DEATH.

31 E 18975

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1417 N. Gay St ST., 8-17 WARD)

2-FULL NAME Ida Hoffman

(a) RESIDENCE No. 1417 N Gay St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | wh | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Hoffman

6 DATE OF BIRTH (month, day, and year) 10/13/1892

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 34 | 4 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt city Md

PARENTS

10 NAME OF FATHER David Fried

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Gertrude Fried

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jacob Hoffman

(Address) 1417 N Gay St

15 Filed FEB 4 1927 By [illegible] Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 10, 1926, to July 13, 1927.

that I last saw h alive on July 13 1927

and that death occurred, on the date stated above, at 10.30 P m.

The CAUSE OF DEATH* was as follows:

Ch. Pulmonary Tb

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? N Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. L. Hornstein, M. D.

2/14, 1927 (Address) 703 Augusta St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mehren Herren Rinn — DATE OF BURIAL 2/16 1927

20 UNDERTAKER Jack Levis — ADDRESS 1439 E Biddle St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18976

CERTIFICATE OF DEATH.

101-001

E 18976

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Md Gen Hosp. St. 4-76 Ward)

2-FULL NAME Hannah Davis Fehrman.

(a) RESIDENCE NO. 736 N. Fayette St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Fehrman

6 DATE OF BIRTH (month, day, and year): Sept 18 85

7 AGE — Years: 41 — Months: 4 — Days: 24 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home 037

(b) General nature of industry, business, or establishment in which employed (or employer): Work at Home

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): England.

PARENTS

10 NAME OF FATHER: Robert Cosy

11 BIRTHPLACE OF FATHER (city or town)

(State or country): England

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant: Charles Fehrman

(Address): 736 N. Fayette St.

Filed FEB 14 1927 Per [signature] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 12 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Flu

(Duration) yrs. mos. 1 ds.

(Signed) [signature] (Coroner) M. D.

2/19 (Address) 143 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Bur

Date of Burial: Feb 14 1927

20 UNDERTAKER: H. McNorton

ADDRESS: 230 N. Green

THE BACK HEREOF, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C. HAMPSON JONES, M.D.

Spec.—7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18977

## CERTIFICATE OF DEATH

185

E 18977

1-PLACE OF DEATH

REGISTERED NO. 19-28

City of BALTIMORE: (No. Municipal Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert J. Scott

(a) RESIDENCE NO. 329 S. Monroe St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. da. How long in U. S. if of foreign birth? yrs. mos. da.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Widowed |

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Mary Jane Scott

6 DATE OF BIRTH (month, day, and year) Sept. 2, 1861

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|---|
| | 65 | 5 | 11 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Paver

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer City of Baltimore

9 BIRTHPLACE (city or town) Baltimore,

(State or country) Maryland

PARENTS

10 NAME OF FATHER James I Scott

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Scotland

12 MAIDEN NAME OF MOTHER Marion (Unknown)

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Scotland

14 Informant Miss Maud Scott

(Address) 329 S. Monroe St.,

15 Filed ..... 19 .....

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb - 13th 1927 19

17 I HEREBY CERTIFY, That I attended deceased from 2-3- 1927, to 2-13 1927,

that I last saw h[illegible] alive on Feb. 12th 1927,

and that death occurred, on the date stated above, at 1 30 A. m.

The CAUSE OF DEATH* was as follows:

Fracture of femur - right

Intertrochanteric

(Accident cause. fell from a ladder

(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) Senile Pneumonia

Cardiac failure

(duration) yrs. mos. 3 ds.

18 Where was disease contracted At work.

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X-Ray - Clinical diagnosis

(Signed) Jacob Rosenau, M. D.

(Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — Date of Burial Feb. 16 1927

20 UNDERTAKER Joseph B Cook — ADDRESS 1003 N. Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18978

## CERTIFICATE OF DEATH.

E 18978

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Chapel Gate Lane St. 28-71 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lawrence Edgar Clarke

(a) RESIDENCE NO. 6 Chapel Gate Lane St. (Ten Hills) WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Child |

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 2-13-26

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | XXX | 11 | 30 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Wm. J. Clarke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Anne Arundel Co. Md.

12 MAIDEN NAME OF MOTHER Mary A. Crowley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore County Md.

14 Informant William J. Clarke (Address) Chapel Gate Lane, Ten Hills

15 Filed FEB 14 1927 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-12 1927.

17 I HEREBY CERTIFY, That I attended deceased from 2-10 .1927. to 2-12 .1927.

that I last saw him alive on 2-11 .1927.

and that death occurred, on the date stated above, at 6.00 A.m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) yrs. mos 6-7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? (Clinical)

(Signed) J. Lloyd Johnson, M. D.

2-13-27 (Address) Frederick & Augusta Sts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral Cemetery

DATE OF BURIAL Feb. 14 1927.

20 UNDERTAKER Joseph B. Cook

ADDRESS 603 Park St

HAMPSON JONES, M.

Par

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-24 A Co.—200 Bks.

1993

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 18979

REGISTERED NO.

E 18979

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 9-18 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Henry Simon

(a) RESIDENCE NO. 1717 Aisken St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | widowed - |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 59 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Austria -

PARENTS

10 NAME OF FATHER Isaac Simon

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Austria

12 MAIDEN NAME OF MOTHER Margaret

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Austria

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... M. D.

Registrar

Per

FEB 14 1927 C. HAMPSON JONES M.D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 27 Feb 13

17 I HEREBY CERTIFY, That I attended deceased from Jan 24 19 27, to Feb 13 19 27, that I last saw h[illegible] alive on Feb 13 19 27, and that death occurred, on the date stated above, at 1 30 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Pancreatitis Complication

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 1/29/27

Was there an autopsy? Yes, surgical & Partial autopsy

What test confirmed diagnosis? Autopsy

(Signed) Johns Hopkins, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Har[illegible] Cemetery 2/14 1927

20 UNDERTAKER ADDRESS

Harry R Ickesman 221 Aisken St

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 18980

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

118-002

E 18980

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St. 9-18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John T. Ruddy

(a) RESIDENCE NO. 1219 E. Lanvale St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? Life yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9/15 1874

7 AGE — Years: 52 Months: 4 Days: 27

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer): City Dept

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore, Md

(State or country)

PARENTS

10 NAME OF FATHER: Austin Ruddy

11 BIRTHPLACE OF FATHER (City or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Ellen Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Frank Ruddy (Address) 1219 E Lanvale St

15 Filed FEB 14 1927 19 C. HAMPSON JONES, M. D. Registrar

Bur

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 2-12-27

17 I HEREBY CERTIFY, That I attended deceased from 2-6-27, 19, to 2-12, 1927.

that I last saw him alive on 2-12, 1927.

and that death occurred, on the date stated above, at 4 55 a m.

The CAUSE OF DEATH* was as follows: Pneumonia Croupous

(duration) yrs. mos 12 da.

CONTRIBUTORY (Secondary) Pachydermia Gens

(duration) yrs. mos 1 da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of 2/9/27

Was there an autopsy? Yes

What test confirmed diagnosis? Gross findings

(Signed) W. P. Smith M. D.

19 (Address) City Hospital

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Cemetery Govans — Date of Burial 2/15 1927

20 UNDERTAKER: George J Ruth — ADDRESS 1735 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18981 E 18981

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 100 S. Mount St. (WARD) 14-28 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Catherine O'Hara

(a) RESIDENCE NO. 100 S. Mount St. ST., 20th WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed or divorced HUSBAND of (or) WIFE of: John J. O'Hara

6 DATE OF BIRTH (month, day, and year): May 24th 1851

7 AGE: Years 76 Months 8 Days 16 If LESS than 1 day, hrs. or min. 18

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Owen Johnston

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Catherine Ann Logan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Rev. H. C. O'Hara

(Address) 100 S. Mount St

Filed FEB 14 1927 HAMPSON JONES, M. D.

Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 10th 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 10, 1926, to Feb 10, 1927.

that I last saw h alive on Feb 9, 1927.

and that death occurred, on the date stated above, at 10:20 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma breast

(duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary): Chronic Nephritis

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) James F. Hagan M. D.

(Address) 1197 E Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: Feb 14 1927

20 UNDERTAKER: H. S. Hepfner

ADDRESS: 1504 N. Paca St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 18982

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

161-001

E 18982

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 139 E Oliver ST. 24-33 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Norma Hinkle

(a) RESIDENCE NO. 139 E Oliver ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 13 1927

7 AGE — Years — Months — Days — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Harry W Hinkle

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Nora Benjamin

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Harry W Hinkle (Address) 139 E Oliver St

15 Filed FEB 14 1927 C. HAMPSON JONES, M. D. Registrar

Ret —

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 13 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 13, 1927, to Feb 13, 1927, that I last saw h[illegible] alive on Feb 13, 1927, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Premature birth

6 mos gestation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Visible

(Signed) Wm Ellis M. D.

2/14 1927 (Address) 1319 Light

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem. DATE OF BURIAL 2/16 1927

20 UNDERTAKER J. J. Fahey & Sons ADDRESS 1318 Eutaw

Spec.—1-12-23—M&T—500 Blks.

E 18983

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

38 E 18983

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 19 Bloom ST. 14-20 WARD)

2-FULL NAME Sallie Carter

(a) RESIDENCE NO. 19 Bloom ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | C | Widowed |

5a If married, widowed, or divorced ~~HUSBAND~~ (or) WIFE of John Carter

6 DATE OF BIRTH (month, day, and year) May 15, 1878

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs or ..... min. |
|---|---|---|---|---|
| 48 | 49 | 8 | 26 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 037

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) West River A.A. Co Md

PARENTS

10 NAME OF FATHER Henry Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) A.A. Co Md.

12 MAIDEN NAME OF MOTHER Delia Holt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) A.A. Co Md

14 Informant Eva Randall

(Address) 719 Bloom st

15 Filed FEB 14 1927 C. HAMPTON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/11 1927

17

I HEREBY CERTIFY, That I attended deceased from ~~Dec~~ ....., 19..., to 2/11 1927,

that I last saw h... alive on 2/11 1927

and that death occurred, on the date stated above, at 2 20 pm

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

Pneumonia

(duration) yrs. mos 1 day ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) ..... M. D.

2/11 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Mt Auburn Cemetery | Feb 14 1927 |

20 UNDERTAKER Mrs Jas. H. Dennis for T. G. Nelson

ADDRESS 4303 Eastman st

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18984

101-001

E 18984

## CERTIFICATE OF DEATH.

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 1512 Light St. 23-32 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edna F. Atkinson

(a) RESIDENCE NO. 1512 Light St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Nov. 29 - 1926

7 AGE: Years | Months: 2 | Days: 14 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): NONE

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country): Md.

PARENTS

10 NAME OF FATHER: Wm. Atkinson

11 BIRTHPLACE OF FATHER (city or town): Md.

(State or country)

12 MAIDEN NAME OF MOTHER: Lillian Ferguson

13 BIRTHPLACE OF MOTHER (city or town): Md.

(State or country)

14 Informant: Mrs Edna

(Address): 1512 Light St.

15 Filed ..... 19 .....

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

2-13-1927

17

I HEREBY CERTIFY, That I attended deceased from Feb. 11, 1927, to Feb 13, 1927,

that I last saw h[illegible] alive on Feb 12, 1927,

and that death occurred, on the date stated above, at 1700 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) .....yrs. .....mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

Is Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Thos F Simms, M. D.

2/13, 1927 (Address) 2878 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cem — Date of Burial: 2/14 1927.

20 UNDERTAKER: J. Fred McCully — ADDRESS: 1308 Fort

FEB 14 1927 HAMPDEN NO. M.

Spec—12-23-21—E.B.R.S.—400 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18985

## CERTIFICATE OF DEATH.

31

E 18985

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1808 Maryland St. 12-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Miller

(a) Residence No. 1808 Maryland St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced, (Write the word.) M

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Fannie Miller

6-DATE OF BIRTH (month, day and year) 1890

7-AGE, 37 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) — 040

(c) Name of employer —

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Edward Miller

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Fannie Miller

(Address) 1808 Maryland St.

15- Filed FEB 14 1927 1927 C. HAMILTON JONES, M. D. Registrar.

Per

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb. 10. 1927

17- I HEREBY CERTIFY, That I attended deceased from Dec 13 1927 to Feb 10 1927

that I last saw h— alive on Feb 10 1927

and that death occurred, on the date stated above, at 5-07 m.

The CAUSE OF DEATH* was as follows: Pulmonary tuberculosis

Infinite

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? Phys. Exam

(Signed) R. Garland Grumbine M. D.

2/14. 19 (Address) 1534 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvary — DATE OF BURIAL: 2/14/27

20-UNDERTAKER: Mrs. R. G. Elliott — ADDRESS: 1725 Eastland

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Every item of information instructions on back of certificates. Exact statement of OCCUPATION is very important. See

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18986

## CERTIFICATE OF DEATH.

90 E 18986

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Provident Hospital ST. 16-23 WARD)

2-FULL NAME Frances Monk

(a) RESIDENCE No. 1107 Harlem Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) — 1885

7 AGE 42 Years | Months | Days | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lawrence Va

PARENTS

10 NAME OF FATHER Peddy Walker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Louisa Hucks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Aunt Ford

(Address) 1107 Harlem Ave.

15 Filed FEB 14 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 5 1927 to Feb 11 1927 that I last saw h[illegible] alive on Feb 11 1927 and that death occurred, on the date stated above, at 2:40 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? 416 N Fremont Ave

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X Ray

(Signed) H. R. Cosby M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 2/14 27

20 UNDERTAKER Samuel Hawkins

ADDRESS 518 Madison

N. B.—WRITE PLAINLY, WITH CARBON INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

Hackerman ✓

# E 18987 HEALTH DEPARTMENT—CITY OF BALTIMORE

91-00 ✓ E 18987

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Home for Aged St. 10 Greenlle WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michala Hackerman

(a) RESIDENCE No. 2100 E Baltimore St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | W | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Calmer Hackerman

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 90 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work old age

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Lazer Rose

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Louis Hackerman

(Address) 2245 Federal

15 Filed FEB 14 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/13 1927

17 I HEREBY CERTIFY, That I attended deceased from June, 1926, to Feb 13, 1927, that I last saw h[illegible] alive on Feb 13, 1927 and that death occurred, on the date stated above, at 9 9 m

The CAUSE OF DEATH* was as follows:

arteriosclerosis

(duration) 9 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) 1810 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Hebrew Friendship | 2/14 1927 |
| 20 UNDERTAKER | ADDRESS |
| Jack Lewis | 1439 E Baltimore |

N.B. WHILE ENTIRELY CONFIDENTIAL, THIS CERTIFICATE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

Moores

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

24-001

E 18988

1-PLACE OF DEATH

REGISTERED NO. E 18988

City of BALTIMORE: (No. 823 Aisquith St. 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William E. Moores

(a) RESIDENCE NO. 823 Aisquith St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gertrude

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..hrs. or ..min.. |
|---|---|---|---|---|
| | 76 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town) Unk

(State or country)

12 MAIDEN NAME OF MOTHER Unk

13 BIRTHPLACE OF MOTHER (city or town) Unk.

(State or country)

14 Informant Gertrude Moores

(Address) 1823 Aisquith st

FEB 14 1927

Filed ..., 19.. HAMPSON JONES, M. D.

Per K.J.C. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/12 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 19, 1926 to Feb 12, 1927

that I last saw him alive on Feb. 12, 1927

and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy 3

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John Dorsch M. D.

2/13, 1927 (Address) 936 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| National Cemetery | 2/14 1927 |
| 20 UNDERTAKER Sol Levinson & Bro | ADDRESS 1127 E Balto St |

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 18989

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 18989 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 3300 Gwynn Oak Ave. Ward) 28-6

2-FULL NAME Bernhard G. Stehl

(a) RESIDENCE NO. 3300 Gwynn Oak Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. 9 mos. 19 ds. How long in U. S., if of foreign birth? 81 yrs. 9 mos. 19 ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | widower |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary J. Stehl

6 DATE OF BIRTH (month, day, and year) Apl. 24/1845

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 81 | 9 | 19 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Accountant

(b) General nature of industry, business, or establishment in which employed (or employer) Office of Revenue

(c) Name of employer B & O. Railroad

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER John Stehl

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Bouesum

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) France

14 Informant J. Herbert Stehl

(Address) 3920 Ridgewood Ave

15 Filed FEB 4 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 13 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb. 9th 1927, to 2-13- 1927, that I last saw him alive on 2-13- 1927, and that death occurred, on the date stated above, at 12 20 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypocarditis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Amerzo Lacca M. D.

, 19 (Address) 3705 Liberty Hts Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. Date of Burial: Feby 15 1927

20 UNDERTAKER: Harry W. Eblen ADDRESS: 1744 W. North Ave

R.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 18990

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18990

## CERTIFICATE OF DEATH.

127

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7 Wilson) (St. or Ave.) (WARD) 27-41

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Sadowski

(a) RESIDENCE NO. 7 Wilson ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Elz Sadowski

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 66 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailor

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Europe

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not Known

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Emma E Sadowsky (Address) 102 Wayne Ave

15 Filed FEB 14 1927 Registrar C. HAMPTON JONES, M. D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 12 1927

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1926 to July 12, 1926 that I last saw h alive on July 12, 1926 and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows: Cancer of Liver

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Jaundice

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer

DATE OF BURIAL: Feb 15 1927

20 UNDERTAKER: Crook Funeral Co.

ADDRESS: 637 W Lexington

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18991

E 18991

## CERTIFICATE OF DEATH.

27-33 101-801

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hospital St. Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Royal A. Ritter

(a) RESIDENCE NO. 117 E. Church St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A. Ritter

6 DATE OF BIRTH (month, day, and year) Aug. 27, 1882

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 44 | 5 | 16 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Geo. F. Obrecht

9 BIRTHPLACE (city or town) Woodlawn,

(State or country) Md.

PARENTS

10 NAME OF FATHER John Wesley Ritter

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Woodlawn, Md.

12 MAIDEN NAME OF MOTHER Josephine Schaffer

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Mrs. Edna Bounds

(Address) 1311 N. Fulton Ave.

15 Filed FEB 14 1927 19

C. HAMPSON JONES, M. D.

Per Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12, 1927

17 I HEREBY CERTIFY That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure (duration) yrs. mos. ds.

(Signed) J. C. Glades M. D.

(Coroner)

(Address) 1436 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olive (Roslyn) Md Date of Burial Feb 15 1927

UNDERTAKER John F Denny ADDRESS 915 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

# E 18992 HEALTH DEPARTMENT—CITY OF BALTIMORE E 18992

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. 15-61 90

CITY OF BALTIMORE: (No.) 2904 (St.) Clifton Ave (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Elizabeth Capps Nugent

(a) RESIDENCE No. 2904 (St.) Clifton Ave (Ward)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jack Capps

6 DATE OF BIRTH (month, day, and year): June 19 1848

7 AGE — Years: 78 — Months: 7 — Days: 25 — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework at home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Princess Anne Co Va

PARENTS

10 NAME OF FATHER: Boyd Beecham

11 BIRTHPLACE OF FATHER (city or town) (State or country): Salli Whitson N C

12 MAIDEN NAME OF MOTHER: N C

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Edgar E Helm (Address) 2904 Clifton ave

15 Filed FEB 14 1927 Registrar C. HAMPSON JONES, M. D.

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 13 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 3, 1925, to Feb 13, 1927, that I last saw h[illegible] alive on Feb 13, 1927 and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Arthritis Deformans

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary): Chronic myocarditis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. K. Allen M. D.

2-18-27 (Address) 2757 W. Mulberry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Feb 16 1927

20 UNDERTAKER: John F Denny — ADDRESS: 715 Lafayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

199753 E 18993

## CERTIFICATE OF DEATH.

38 E 18993

REGISTERED NO. _____

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 16-22 Ward)

2-FULL NAME Augustus Baby Travers

(a) RESIDENCE NO. 1710 W. Lanvale St. Balto St. Mel Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Col | Baby |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1-6-27

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 3 3 Days | | 33 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Travers

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 FEB 14 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Feb 9, 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan 30, 19 27, to Feb 9, 19 27,

that I last saw h[illegible] alive on Feb 9, 19 27,

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Congenital Syphilis

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? J. H. Hospital

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) W. E. Hamilton, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 19

JOHNS HOPKINS HOSPITAL

20 UNDERTAKER ADDRESS

Commissioner Health.

FEB 14 1927

Per [illegible]

WARNING.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. –7-17-26—A Co.—200 Bks.

E 18994

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E·18994

REGISTERED NO. 100-08

1-PLACE OF DEATH

City of BALTIMORE: (No. 1427 N. Wolfe St. 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edna L. Burker

(a) RESIDENCE NO. 1427 N. Wolfe St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White.

5 Single, Married, Widowed, or Divorced, (write the word): Sing'l.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept. 28 1 1926

7 AGE — Years: — Months: 4 Days: 15.

IF LESS than 1 day ___ hrs. or ___ min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 220

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Harry F. Burker

11 BIRTHPLACE OF FATHER (City or town) (State or country): Balto My

12 MAIDEN NAME OF MOTHER: Edna J. Seal

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant: Mr. Harry F. Burker

(Address) 1427 N Wolfe St

15 Filed FEB 14 1927 19 C. HAMPSON JONES, M. D. Registrar

Per R.C.S.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2-13 1927

17 I HEREBY CERTIFY, That I attended deceased from 2-10, 1927, to 2-13, 1927.

that I last saw her alive on 2/13 1927.

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis Disseminated

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Edmund Pelgram

(Signed) Edmund Pelgram, M. D.

2/13/27 (Address) 15 W Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — Date of Burial: Feb. 15 1927

20 UNDERTAKER: Henry Storck & Son — ADDRESS: 1301 E Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THE tion should be carefully supplied. AGE should be OF DEATH in plain terms, so that it may be pro very important. See instructions on back of cer

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E. 18995

1-PLACE OF DEATH

16 E 18995

REGISTERED NO.

City of BALTIMORE: (No. Johns Hopkins Hospital St. 8-17 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Baby Bailey

(a) RESIDENCE NO. 145 Carlisle Place Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Black

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb. 4, 1927

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | | | Six | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 000

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country): Md.

PARENTS

10 NAME OF FATHER: John Bailey

11 BIRTHPLACE OF FATHER (city or town):

(State or country): ?

12 MAIDEN NAME OF MOTHER: Ida Bailey

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Md.

14 Informant: C. H. Peckham

(Address): Johns Hopkins Hospital

FEB 14 1927, 19

C. HAMPSON JONES, M. D. Registrar

(1935) ARH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2 Feb. 10 19 27

17 I HEREBY CERTIFY, That I attended deceased from Feb. 4 19 27 to Feb. 10 19 27,

that I last saw him alive on Feb. 10 19 27

and that death occurred, on the date stated above, at 10 10 A. m.

The CAUSE OF DEATH* was as follows:

Central Hemorrhage

(Birth Injury)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) C. H. Peckham, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

JOHNS HOPKINS HOSPITAL

Commissioner of Health. FEB 14 1927

FEB 14 1927

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18996

E 18996

## CERTIFICATE OF DEATH

REGISTERED NO. 37

1-PLACE OF DEATH Colonial Hospital

City of BALTIMORE: (No. 1122 N. Monroe St. 9-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry P. Baker

(a) RESIDENCE NO. 2824 Montebello Ave St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. 1 mos. 14 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Single. |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 29 1895

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 31 | 1 | 14 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md

(State or country)

PARENTS

10 NAME OF FATHER George M. Baker

11 BIRTHPLACE OF FATHER (City or town) Balto Md

(State or country)

12 MAIDEN NAME OF MOTHER Virginia Baker

13 BIRTHPLACE OF MOTHER (city or town) Balto Md

(State or country)

14 Informant Mrs Virginia Baker

(Address) 2824 Montebello Av

15 Filed FEB 14 1927, 19

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 February 13

17 I HEREBY CERTIFY, That I attended deceased from Jan 27, 1927, to Feb 13, 1927,

that I last saw h alive on , 19 ,

and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary T.B. Laryngeal tuberculosis

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical exam

(Signed) [illegible] M. D.

2/15/27 19 (Address) Colonial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — Date of Burial Feb 16 1927

20 UNDERTAKER Henry Hoch Son — ADDRESS 1301 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of form should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 7-17-26—A Co.—200 Bks.

E 18997.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18997.

## CERTIFICATE OF DEATH

38

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. University Hospital St. 4-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alma L Davis

(a) RESIDENCE NO. 1117 Derwood St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Black | Married |

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Chas Davis

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min.. |
|---|---|---|---|---|
| | 45 ? | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife — 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Washington, D C.

(State or country)

PARENTS

10 NAME OF FATHER Unk.

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER Unk.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Chas. Davis

(Address) 1117 Derwood Ave, City.

15 Filed ... C. HAMPSON JONES, M. D. Registrar

By ...

FEB 4 1927

104

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 10 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 20, 1927, to Feb. 10, 1927, that I last saw h.. alive on Feb. 10, 1927, and that death occurred, on the date stated above, at 1.35 a. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos 2 1 ds.

CONTRIBUTORY Syphilis

(Secondary)

(duration) ? yrs. mos. ds.

18 Where was disease contracted

If not at place of death? On street car -

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E R Miller, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial 19 |
|---|---|
| 20 UNDERTAKER | ADDRESS |

JOHNS HOPKINS HOSPITAL

Commissioner of Health

FEB 12 192

Per. Wm. R. WOODALL

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

**E 18998**

HEALTH DEPARTMENT—CITY OF BALTIMORE

101 901 ✓

**E 18998**

## CERTIFICATE OF DEATH

1-PLACE OF DEATH Mercy Hospital

City of BALTIMORE: (No. Lombard & Smith St., Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Rylon (or Riley)

(a) RESIDENCE NO. 537 Robert St. Ward Baltimore Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | Colored | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) ✓ 1899

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min.. |
|---|---|---|---|---|
| | 28 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) ✓

(State or country) ✓

PARENTS

10 NAME OF FATHER ✓

11 BIRTHPLACE OF FATHER (City or town) ✓

(State or country)

12 MAIDEN NAME OF MOTHER ✓

13 BIRTHPLACE OF MOTHER (city or town) ✓

(State or country)

14 Informant ✓

(Address)

FEB 14 1927 C. HAMPSON JONES, M. D. Registrar

Per 101.2

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 30 1927 to Feb 5th 1927

that I last saw h[illegible] alive on Feb 5th 1927

and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Marasmus Bilateral Lobar Pneumonia

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Acute Cordiac Failure

(duration) yrs. mos 1 ds.

18 Where was disease contracted

If not at place of death? B & O R. R (Cab) Dayton.

Did an operation precede death? No Date of none

Was there an autopsy? none

What test confirmed diagnosis? Clinical Course

(Signed) A B Hendrix M. D.

, 19 (Address) Mercy Hospital Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial 19 |
|---|---|
| 20 UNDERTAKER | ADDRESS |

JOHNS HOPKINS HOSPITAL

Dept. of Health FEB 12 1927

Per WM. E. WOODALL

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 18999

## CERTIFICATE OF DEATH

E 18999

REGISTERED NO. 90

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. King

(a) RESIDENCE NO. 617 Brunswick St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | married |

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Catherine Quinn

6 DATE OF BIRTH (month, day, and year) May 10, 1869

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 57 | 9 | 1 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) G

(c) Name of employer Greenwald Packing Co.

9 BIRTHPLACE (city or town) Ireland
(State or country)

PARENTS

10 NAME OF FATHER Michael King

11 BIRTHPLACE OF FATHER (City or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Shanna

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Son John King
(Address) 617 Brunswick St

15 Filed FEB 14 1927 C. HAMPSON JONES, M. D.
Per RRR Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-11 1927

I HEREBY CERTIFY, That I attended deceased from 2-10, 1927, to 2-11, 1927, that I last saw him alive on 2-11, 1927, and that death occurred, on the date stated above, at 1.05 P. m.

The CAUSE OF DEATH* was as follows: Myocardial Insufficiency

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy?

What was confirmed diagnosis? Chronic Endocarditis

(Signed) W. P. Clark, M. D.

(Address) St Agnes Hospital

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Cathedral Cemetery | 2/15 1927 |
| 20 UNDERTAKER | ADDRESS |
| Henry W. Means & Son | 1054 Baltimore |

Spec.—1-12-23—M&T—500 Bks.

E 19000

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19000

## CERTIFICATE OF DEATH.

REGISTERED NO. 12-49

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4000 Old York Rd ST., (or) WARD)

2-FULL NAME Henry Hickman Smallwood

(a) RESIDENCE NO. 4000 Old York Road ST., 4 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. 10 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary M. Smallwood

6 DATE OF BIRTH (month, day, and year) April 29-1856

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 70 | 9 | 16 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired farmer

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Fulton Howard Co. Md.

PARENTS

10 NAME OF FATHER Philip Smallwood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Fulton Maryland

12 MAIDEN NAME OF MOTHER Martha Burgette

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Maude E. Shivery

(Address) 4000 Old York Road

15 [illegible] 1927 C. HAMPSON JONES, M. D. Registrar

Per Robt

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 14. 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov. 27, 1926, to Feb. 14, 1927.

that I last saw h. m alive on Feb. 14, 1927.

and that death occurred, on the date stated above, at 6.30 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 1 yrs. 6 mos. ? ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Test meal - X-ray. M

(Signed) C. D. Creighton, M. D.

2/14 1927 (Address) 3949 Greenmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| St Marks Howard Co Md | Feb 16 1927 |
| 20 UNDERTAKER | ADDRESS |
| Henry H Jenkins Sons Co | Orchard & Mc Callister St |

FEB 14 1927

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19001

E 19001

## CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4012 Brookline Ave. ST. 15-63 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Pamelia Carroll

(a) RESIDENCE NO. 4012 Brookline Ave. ST., WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 2 mos. 26 ds. How long in U. S., if of foreign birth? 49 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Nov-16-1877

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 49 | 2 | 26 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas C. Carroll

11 BIRTHPLACE OF FATHER (city or town) Portsmouth (State or country) Va.

12 MAIDEN NAME OF MOTHER Margaret Orem

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Mr. Charles J. Carroll (brother)

(Address) 4012 Brookline Ave.

15 B 14 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/11 - 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept - 28, 1926, to Feby - 11 - 1927.

that I last saw her alive on Jan F 13 - 1927.

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency chronic with gradual decompensation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) Franklin Cale, M. D.

, 19 (Address) 720 Gmson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Loudon Park Cemetery

DATE OF BURIAL Feb - 15 1927

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

7 ... Name of Undertaker, with undating ink—this is a permanent record. ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSI... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19002

90 E 19002

## CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Chelford Apartments St., 27-47 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Edward French

(a) RESIDENCE NO. Chelford Apts. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. 1 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary Harrison French

6 DATE OF BIRTH (month, day, and year) December 16th. 1853

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 73 | 1 | 27 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocer

(b) General nature of industry, business, or establishment in which employed (or employer) Groceries 034

(c) Name of employer Self

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland.

PARENTS

10 NAME OF FATHER John French

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Hamilton

13 BIRTHPLACE OF MOTHER (city or town) ? ? ?

(State or country) Pennsylvania.

14 Informant Mrs. Mary E. French, wife.

(Address) Chelford Apts., City.

Filed FEB 14 1927 C. HAMPSON JONES, M. D. Registrar

BY

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 13 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said Inquest

Inquest, autopsy or inquiry.) find that said deceased came to h... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tubular Disease of Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) John H. Crissman M. D.

(Coroner)

Feb 13, 1927 (Address) 3632 Roland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? Roland Ave—40th-Stes.

Former or usual residence Chelford Apts.

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery Date of Burial Feb-16- 19

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODELL, Successor) ADDRESS 108 W. NORTH AVE.

DATA ANALYSIS AND HEALTH NEST THAT

WR—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICI OF DEATH in plain terms, so that it may be properly classified. Exact statem very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19003

E 19003

## CERTIFICATE OF DEATH.

11-001

27-56

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. [illegible] Woodland-Av. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Howard Tinsmus

(a) RESIDENCE NO. [illegible] Woodland-Av. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 3 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

Resident.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lucy W. Tinsmus

6 DATE OF BIRTH (month, day, and year) Oct-31-1877

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 49 | 3 | 15 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter G/S

(b) General nature of industry, business, or establishment in which employed (or employer) Building Work.

(c) Name of employer Self.

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Edward L. Tinsmus

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Matilda Frazier

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant Mrs. Lucy W. Tinsmus, (wife)

(Address) [illegible] Woodland-Av., City.

15 FEB 14 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-13-1927.

17 I HEREBY CERTIFY, That I attended deceased from 2-7-, 1927, to 2-13-, 1927; that I last saw him alive on 2-13-, 1927, and that death occurred, on the date stated above, at 6.45a m.

The CAUSE OF DEATH* was as follows:

Influenza. 4 ds.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of [illegible]

Was there an autopsy? No

What test confirmed diagnosis? [illegible]

(Signed) Merrill Lovell, M. D.

, 19 (Address) 305 Liberty Hgts. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL Feb-15-1927.

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

INK—THIS IS A PERMANENT RECORD. Every item should be stated EXACTLY. PHYSICIANS state mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19004 E 19004

## CERTIFICATE OF DEATH

REGISTERED NO. 57

1-PLACE OF DEATH

City of BALTIMORE: (No. 719 W. Fayette St. 4-76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lydia E. Ensor

(a) RESIDENCE NO. 719 W. Fayette St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S. if of foreign birth? yrs. mos. da.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harry G. Ensor

6 DATE OF BIRTH (month, day, and year): Feb. 27, 1870

7 AGE: Years 56 Months 11 Days 21 27

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town): Balto. (State or country) Md

PARENTS

10 NAME OF FATHER: John Ryan

11 BIRTHPLACE OF FATHER (City or town): (State or country) Canada

12 MAIDEN NAME OF MOTHER: Charlotte Lee

13 BIRTHPLACE OF MOTHER (city or town): (State or country) Carroll Co. Md.

14 Informant (Address): Harry G. Ensor, 719 W. Fayette St.

15 FEB 14 1927 C. HAMPSON JONES, M. D. Registrar

Per RRR

Dr. Van Williams Carlton & Edn. Co.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 13th 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 20th 1927 to Feb 13th 1927 that I last saw her alive on Feb 12th 1927 and that death occurred, on the date stated above, at 8:30 A m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 4 yrs. mos. da.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia (duration) yrs. mos. 5 da.

18 Where was disease contracted if not at place of death? +

Did an operation precede death? no Date of X

Was there an autopsy? no

What test confirmed diagnosis? Symptoms & Lab

(Signed) J. Ben Williams M. D.

. 19 (Address) 601 Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore City. Date of Burial 2/15 1927

20 UNDERTAKER: Margaret G. Flynn ADDRESS 1422 Light

NOTE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Cor.—1-12-23—M&T—100 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19005

E 19005

## CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 3108 N. Calvert ST. 12-50 WARD)

2-FULL NAME Cyrus. Creugh.

(a) RESIDENCE NO. 3108 N. Calvert ST., 12 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| M | W. | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret H Creigh

6 DATE OF BIRTH (month, day, and year) May 12. 1836

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 90 | 9 | 1 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Noble Business
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer L of H

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER David Creigh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Arbuckle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mrs Elmer Lungren (Address) 3108 N Calvert St

15 Filed FEB 14 1927, 19 C. HAMPSON JONES, M. D. Registrar Per ARR

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 13 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tubular Disease of Heart

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Chas H Corner, M. D. (Coroner.)

2/14, 1927 (Address) 3632 Roland Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Staunton Va DATE OF BURIAL Feb 15 1927

20 UNDERTAKER H. Cook ADDRESS 300 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19006

## CERTIFICATE OF DEATH

E 19006

1-PLACE OF DEATH

REGISTERED NO. 23-32

City of BALTIMORE: (No. 1740 Hanover St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gloria Elizabeth Barnes

(a) RESIDENCE NO. 1740 Hanover St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 8 mos. 13 ds. How long in U. S. If of foreign birth? — yrs. — mos. — ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): May 21st 1926

7 AGE — Years: — Months: 8 Days: 23 IF LESS than 1 day ... hrs. or ... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particolar kind of work: None

(b) General nature of indostry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER: John A. Barnes

11 BIRTHPLACE OF FATHER (City or town): Baltimore

(State or country) Md

12 MAIDEN NAME OF MOTHER: Mary E. Arnold

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country) Md

14 Informant: Mrs. Mary E. Barnes

(Address) 1740 Hanover St.

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 13th 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 12th 1927 to Feb. 13th 1927

that I last saw her alive on Feb. 12th 1927

and that death occurred, on the date stated above, at 5 45 a. m.

The CAUSE OF DEATH* was as follows:

Diarrhea & enteritis

(duration) — yrs. — mos. 1½ ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) Evans Legible M. D.

2/14. 1927 (Address) 224-26 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery

Date of Burial: 2/16 1927

20 UNDERTAKER: W. Z. Cook

ADDRESS 502 E. Hoff

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

2/14 1927

Spec.—1-12-23—M&T—500 Bks.

Henry Frohboese.

# E 19007. HEALTH DEPARTMENT—CITY OF BALTIMORE. E 19007.

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Joseph's Hospital

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

REGISTERED NO. 26-41

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Frohbate (Henry Frohboese)

(a) RESIDENCE NO. Belair Rd & Glenwood Ave., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male. | white | Single. |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of 5

6 DATE OF BIRTH (month, day, and year) 1868

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 59 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) 0151

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Henry Frohboese

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sophia Gunter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Wm. J. Lyons

(Address) 818 E. 22nd St

15 C. HAMPSON JONES, M. D.

FEB 14 1927 Per 19 ..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/13/27 19

17 I HEREBY CERTIFY, That I attended deceased from Feb 12, 1927, to Feb 13, 1927, that I last saw h— alive on Feb 13, 1927, and that death occurred, on the date stated above, at 10.20 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Clement R. Moore, M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Forthcoming — DATE OF BURIAL Feb 16 1927

20 UNDERTAKER Wm Cook — ADDRESS 307 E Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 19008 — 38 E 19008

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1112 (St.) Born Alley (Ward) 18-26

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva Hall

(a) RESIDENCE NO. 1112 (St.) Born Alley WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Marshall Hall

6 DATE OF BIRTH (month, day, and year): Mch 1869

7 AGE: Years 57 | Months 11 | Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: J. J. Moody

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Clarence Hall

(Address) 1112 Born Alley

C. HAMPSON JONES, M. D.

8 14 1927 19 Per ... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 13, 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 11, 1927, to Feb. 13, 1927.

that I last saw her alive on Feb. 11, 1927.

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage from rupture of Aortic Aneurysm

(duration) yrs. 6 mos. (?) ds.

over

CONTRIBUTORY (Secondary) /

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None.

(Signed) H. Macco Williams M. D.

2-4-27 (Address) 1830 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem — DATE OF BURIAL: July 15 1927

20 UNDERTAKER: John O. Mitchell — ADDRESS: 1900 Eutaw Pl

IMPORTANT—THIS IS A PERMANENT RECORD. E... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19009

E 19009

## CERTIFICATE OF DEATH.

REGISTERED NO._____

1-PLACE OF DEATH James Robertson Lead Co.

City of BALTIMORE: (No. Henrietta & Howard Sts. 23-32 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Lineberger.

(a) RESIDENCE NO. 108 W. Randall St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male. | White. | Single. |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year)
February 16, 1857.

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| 69 | 59 | 11 | 27 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Watchman.
(b) General nature of industry, business, or establishment in which employed (or employer) Jl2
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Elkridge, Md.

PARENTS

10 NAME OF FATHER Samuel Lineberger.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Cotonsville, Md.

12 MAIDEN NAME OF MOTHER Mary A. Meushaw.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) A.A.Co Md.

14 Informant Ella Hastings, (sister)
(Address) Elkridge, Md.

15 Filed 1927 C. HAMPSON JONES, M. D.
Registrar
Per

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 12, 1927. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Wm. Reinhardt (Coroner) M. D.

2/14 1927 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
In place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Melville Howard Co. Date of Burial Feb. 15 1927

20 UNDERTAKER Wm Cole ADDRESS 532 E. N. Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

E 19010

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129 E 19010

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 411 S. Ellwood Ave. St. 1-2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Diamond A. Hannigan,

(a) RESIDENCE NO. 411 S. Ellwood Ave. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 0 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Laura V. Hannigam

6 DATE OF BIRTH (month, day, and year) July 31, 1871

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 55 | 6 | 12 13 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) R.R.

(c) Name of employer Penna. R.R.

9 BIRTHPLACE (city or town)_____

(State or country) Pennsylvania

PARENTS

10 NAME OF FATHER John Hannigan

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Lydia Mitzer

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Pa

14 Informant Mrs Laura V. Hannigan

(Address) 411 S. Ellwood Ave.

Filed 2 14 1927 C. HAMPSON JONES, M. D.

Per _____ Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 13 19 27

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 19 27, to Feb 13, 19 27, that I last saw him alive on Feb 13, 19 27, and that death occurred, on the date stated above, at 3 09 p.m.

The CAUSE OF DEATH* was as follows:

Uremic Toxemia - (Coma)

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph L. Uhler M. D.

Feb 16 19 27 (address) 1450 Bonney

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Stewards Tower Mt Pleasant Cemetery Penna — Date of Burial Feb. 16, 19 27

20 UNDERTAKER E LeRoy Stiffler — ADDRESS 125 E. North Ave

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

9-712

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19011

## CERTIFICATE OF DEATH.

X 129 E 19011

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Floyd R. Bowman

(a) RESIDENCE NO. Timberville - Va St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Married |

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Bowman

6 DATE OF BIRTH (month, day, and year) July 9 1886

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 40 | 7 | 5 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Producer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) Va.

PARENTS

10 NAME OF FATHER David Bowman

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Va

12 MAIDEN NAME OF MOTHER Katherine Archart

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Va

14 Informant Nearest

(Address) JOHNS HOPKINS HOSPITAL

Rec'd. 19 C. HAMPSON JONES, M. D.

Per _____ Registrar

FEB 15 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 14 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan 28 1927, to Feb 14 1927, that I last saw h.. alive on Feb 14 1927, and that death occurred, on the date stated above, at 11 30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Uremia - 10 days. 9 (History)

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes.

What test confirmed diagnosis? laboratory

(Signed) W. Lindsay Dill, M. D.

2/14/27 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Timberville Va Date of Burial Feb 15 1927

20 UNDERTAKER Wm J Tichner Sons ADDRESS Norfolk Va

NOTE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

101-001 ✓

E 19012

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 103 N Read Ave ST. 27-56 (WARD)

2-FULL NAME John Agapitos

(a) RESIDENCE No. 103 N Read ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

E 19012

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed, or Divorced~~ (write the word): ~~Married~~ Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): 1901

7 AGE: Years 26; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Asst Manager

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer: Andrew & Louis Agapitos

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Andrew Agapitos

11 BIRTHPLACE OF FATHER (city or town) (State or country): Argos

12 MAIDEN NAME OF MOTHER: Fotine

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Argos

14 Informant: Milton Bushar (Address) 103 N Read ave

15 Filed ... 19 ... C. HAMPSON JONES, M. D. Registrar

FEB 15 1927 Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 13 1927

17 I HEREBY CERTIFY, That I attended deceased from 2-9-, 1927, to 2-13, 1927, that I last saw him alive on 2-13, 1927, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) S. Q. Amarco, M. D.

2/15, 1927 (Address) 1604 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem.

DATE OF BURIAL: 2-16 1927

20 UNDERTAKER: Robert Brooks & Son

ADDRESS: Calhoun Hollins

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

Dr Ruby

E 19013

## CERTIFICATE OF DEATH.

E 19013

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 15 E Mulberry St. 425 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henretta Butler

(a) RESIDENCE NO. 15 E Mulberry St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Col | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| about 75 | | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House maid

(b) General nature of industry, business, or establishment in which employed (or employer) Op

(c) Name of employer Alexander Cummings

9 BIRTHPLACE (city or town)

(State or country) Frederick Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) unknown

14 Informant Alla Cummings

(Address) 15 E Mulberry St.

Filed FEB 15 1927 C. HAMPSON JONES, M. D.

Per R.C. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 12 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Sudden (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Feb 14 1927 (Coroner) (Address) 1642 E Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Date of Burial Feb 15 1927

20 UNDERTAKER Franklin W Seitz ADDRESS 709 W 33rd St.

P.S.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19014

## CERTIFICATE OF DEATH.

31

E 19014

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 911 Myrtle Ave (Street) (WARD) 7-26

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Lane

(a) RESIDENCE No. 911 Myrtle Ave St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Col | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec-12-1907

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 19 | 2. | 1 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Watson Grain Yard

9 BIRTHPLACE (city or town) Essex Co

(State or country) Virginia

PARENTS

10 NAME OF FATHER Carter Lane

11 BIRTHPLACE OF FATHER (city or town) Essex Co

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Braxton

13 BIRTHPLACE OF MOTHER (city or town) Essex Co.

(State or country) Virginia

14 Informant Mary Lane

(Address) 911 Myrtle Ave

15 Filed FEB 15 1927 C. HAMPSON JONES, M. D.

Per Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb-13 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan-2, 1927, to Feb-13, 1927,

that I last saw him alive on Feb-13, 1927

and that death occurred, on the date stated above, at 7 P m

The CAUSE OF DEATH* was as follows:

Chr Pulmonary Tuberculosis.

(duration) — yrs. 5 mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Pulmonary Tuberculosis

(Signed) David Evans M. D.

2/14 1927 (Address) 1212 N Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laytons Wharf DATE OF BURIAL Feb 15/27

20 UNDERTAKER David Easton ADDRESS 716 Park

MOTHER SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 19015

HEALTH DEPARTMENT—CITY OF BALTIMORE

36-004

E 19015

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (Johns Hopkins Hospital) St. 18-26 (Ward)

2-FULL NAME Peachie Boyd -

(a) RESIDENCE NO. 921 George St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 Color or Race: col | 5 Single, Married, Widowed, or Divorced, (write the word): married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6-17-1900

7 AGE: 26 Years 27 | Months 7 | Days 25 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town).....

(State or country) Va.

PARENTS

10 NAME OF FATHER Bert Brayton

11 BIRTHPLACE OF FATHER (city or town).....

(State or country) Va -

12 MAIDEN NAME OF MOTHER Stella Carr -

13 BIRTHPLACE OF MOTHER (city or town).....

(State or country) Va.

14 Informant Records

(Address)

15 Filed FEB 15 1927 Per RM

Registrar C. HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 Feb 12

17 I HEREBY CERTIFY, That I attended deceased from Jan. 7, 1927, to Feb 12, 1927, that I last saw h.e. alive on Feb 12, 1927, and that death occurred, on the date stated above, at 2 30 P m.

The CAUSE OF DEATH* was as follows:

Salpingitis subacute bilateral with Tubo ovarian abscesses bilateral.

(duration) .....yrs. 3 mos. .....ds.

CONTRIBUTORY (Secondary) Operative hemorrhage. shock.

(duration) .....yrs. .....mos. No time.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 2/12/27.

Was there an autopsy? yes Blood pressure.

What test confirmed diagnosis?

(Signed) R. L. Faulkner, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Middlesex Va. Date of Burial Feb 15/27

20 UNDERTAKER David Parker ADDRESS Penna

NOTICE PLEASE, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19016

## CERTIFICATE OF DEATH.

× 129 E 19016

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

City of BALTIMORE: (No. 17-24 St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hattie Graves

(a) RESIDENCE NO. 637 N. Hoffman St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1884

7 AGE: Years 43; Months; Days; IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) N. Car.

PARENTS

10 NAME OF FATHER Richard Kenfield

11 BIRTHPLACE OF FATHER (city or town)

(State or country) N. Car.

12 MAIDEN NAME OF MOTHER Susan Claybis

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) N. Car

14 Informant Records.

(Address) JOHNS HOPKINS HOSPITAL

Filed FEB 15 1927 H. HANSON JONES, M. D. Registrar

By LK

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 Feb 14

17 I HEREBY CERTIFY, That I attended deceased from Oct. 21 1926, to Feb 14 1927, that I last saw h.r. alive on Feb 14 1927, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Hypertension Chronic Nephritis

Myocardial Insufficiency

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) Milton Abrey, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Elizabeth City N.C. Date of Burial: Feb 15 1927

20 UNDERTAKER: Hand Funeral Home

ADDRESS: 516 Gay St.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Pks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 19017 (1-PLACE OF DEATH)

129

E 19017 REGISTERED NO.

City of BALTIMORE: (No. 417 N. Gilmor St., 19-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Squire Johnson

(a) RESIDENCE NO. 417 N. Gilmor St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Negro

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Augusta Johnson

6 DATE OF BIRTH (month, day, and year): April 2nd 1855

7 AGE: Years 70 | Months 10 | Days 12 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer): Union Abbatior

(c) Name of employer: Union Abbatior

9 BIRTHPLACE (city or town)

(State or country): Warrenton Va.

PARENTS

10 NAME OF FATHER: Ned. Johnson

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Bakkkax Va.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Va.

14 Informant: Jas. H. Johnson

(Address): 417 N. Gilmor St.

15 Filed FEB 15 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: Feb. 13th. 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 20th. 19 27, to Feb. 13th. 1927, that I last saw him alive on Feb. 13th. 1927, and that death occurred, on the date stated above, at 9;30a.m

The CAUSE OF DEATH* was as follows:

Mitral Ins.

(duration) 1.6 ? yrs. mos. ds.

CONTRIBUTORY (Secondary): Ch. Int. Nephritis

(duration) yrs. 6 mos. ? ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Phys. Physical Exam. Urinal

(Signed) Walter J. Jackson, M. D.

, 19 (Address) 1631 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Zion Cemetery — Date of Burial: Feb 5, 1927

20 UNDERTAKER: Mrs. Katie R. Williams — ADDRESS 722 N. Schroeder St

(If information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.)

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19018

## CERTIFICATE OF DEATH

167-001

REGISTERED NO. E 19018

1-PLACE OF DEATH

City of BALTIMORE: (No. 601 N Pulaski St. 16-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Morris Heyman

(a) RESIDENCE NO. 601 N Pulaski St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fannie Aronoff

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 42 | - | - | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinett maker

(b) General nature of industry, business, or establishment in which employed (or employer) Oil

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Fannie Heyman

(Address) 601 N Pulaski St

15 Filed Feb 15 1927 C. HAMPSON JONES, M. D. Registrar

Per

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 13 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide

Ill. Gas Poisoning

(Duration) yrs. mos. 4 hr

CONTRIBUTORY (Secondary) Asphyxia

(Duration) yrs. mos. 1 hr

Feb 14 1927 (Signed) Geo C Lentz Pilato M. D. (Coroner)

(Address) 1431 61 Jersey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Baltimore Hebrew Cemetery Feb 15 1927

UNDERTAKER ADDRESS

S Levenberg 1127 E Pratt St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FEB 15 1927

Spec.—12-825—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 19019

109-002

E 19019

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL S 3-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Hill

(a) RESIDENCE NO. 102 S Caroline St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | Col | — |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 12. 30 - 26.

| 7 AGE Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|
| — | 1 | 13 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work bld

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto.

PARENTS

10 NAME OF FATHER Charlie Hill

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va.

12 MAIDEN NAME OF MOTHER Bessie Hill

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Records

(Address)

15 Filed ... 19... HARRISON JAMES M D Registrar

FEB 15 1927 RJC

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 27

Feb 13

17 I HEREBY CERTIFY, That I attended deceased from Jan 26 19 27, to Feb 13, 19 27, that I last saw h~~im~~ alive on Feb 13, 19 27, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Acute Rhino-pharyngitis

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted

If not at place of death? 102 S. Caroline.

Did an operation precede death? No. Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) H. E. Handley, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury cemetery — Date of Burial Feb 17 19 27

20 UNDERTAKER Edward Bryan — ADDRESS 1631 Orleans St

THE WHITE PAPER, WITH CARBON ATTACHED, THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19020

E 19020

## CERTIFICATE OF DEATH.

90

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 1425 E. Fayette St. 5-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Belle Anderson

(a) RESIDENCE NO. 1425 E. Fayette St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | col | widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) 1879

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 48 yrs | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of Industry, business, or establishment in which employed (or employer) _____

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) _____

(State or country) Md.

PARENTS

10 NAME OF FATHER Thomas Stewart

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Johnson

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Md

14 Informant Margaret Stewart

(Address) 1425 E. Fayette

15 Filed FEB 15 1927, 19 HAMPSON JONES, M. D. Registrar

FEB 15 1927

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 12 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said _____ (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Probably Thyocardities

(Duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) J. Gill Waller M. D.

(Coroner)

2/14/27 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Magnolia A. A. Co church cemetery

Date of Burial Feb 15 1927

20 UNDERTAKER Edward Bryan

ADDRESS 691 Orleans St

I. WHITE PERSONS, WITH CAUSE OF DEATH. This Certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

# E 19021 HEALTH DEPARTMENT—CITY OF BALTIMORE

107-003

107 E 19021

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Md General Hospital (Street) 25-26 (WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augustus Cunningham

(a) RESIDENCE NO. 24 8th St. Fairfield ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | Black | Married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 22 1902.

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 24 | 3 | 19 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lumberman do

(b) General nature of industry, business, or establishment in which employed (or employer) Lumber

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore md
(State or country)

PARENTS

10 NAME OF FATHER James Cunningham

11 BIRTHPLACE OF FATHER (city or town)
(State or country) S. Carolina

12 MAIDEN NAME OF MOTHER Regina Clark

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) N. Carolina

14 Informant Hospital Records
(Address)

15 Filed FEB 15 1927 C. HAMPSON JONES, M. D. Registrar
Per RR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 24 1927 to Feb 11 1927.

that I last saw h alive on Feb 11 1927,

and that death occurred, on the date stated above, at 10.45 P ms.

The CAUSE OF DEATH* was as follows:

Pulmonary abscess

(duration) yrs. mos 20 ds.

CONTRIBUTORY (Secondary) Toxemia & Pulmonary abscess

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Thos. Hampson Jones, M. D.

1927 (Address) 1 E. Madison St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvery Cem. DATE OF BURIAL Feb 15 1927

20 UNDERTAKER J. L. & S. Brown & Son ADDRESS 108 W. Monty St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19022

1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

Registered No. 159 E 19022

City of BALTIMORE, (No. 2025 E Chase St., 7 8 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Evelyn Conway Herald

(a) Residence No. 2025 E. Chase St., 8 Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1½ yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Jan 16 1927

7-AGE, 28 yrs. 30 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER Daniel Conway

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER, Myrtle Marshall

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

14- (Informant) Mrs. Evelyn Herald

(Address) 2025 E Chase St

15- FEB 15 1927 T. HAMPSON JONES, M. D. Registrar.

Per

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 14 1927

17- I HEREBY CERTIFY, That I attended deceased from Feb 11 1927 to Feb 14 1927

that I last saw h[e]r alive on Feb 13 1927

and that death occurred, on the date stated above, at 10.20 A.M.

The CAUSE OF DEATH* was as follows:

Congenital Cardiac Malformation

(Mitral Valve)

(Duration) yrs. mos. 30 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) D. Peterson M. D. M. D.

2/14/27, 19 (Address) 1305 N. Patterson Pk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, St. Peter's Cemetery DATE OF BURIAL, 2/16, 19 27

20-UNDERTAKER, George L. Rust ADDRESS 1725 Hartford Ave

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 19023

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

179 E 19023

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 1341 E. North Ave ST. 13-59 WARD)

2-FULL NAME Annie E. Limpoth

(a) RESIDENCE No. 1341 E. North Ave. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William Limpoth

6 DATE OF BIRTH (month, day, and year): 3/9/1863

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs or ....min |
|---|---|---|---|---|
| | 63 | 11 | 4 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Christian Krafft

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Annie E. Knapp

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Miss Bessie Limpoth

(Address) 1341 E North Ave

15 Filed FEB 15 1927 C. HAMPSON JONES, M. D. Registrar

Per

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): February 13 1927

17

I HEREBY CERTIFY, That I attended deceased from February 12, 1927, to February 13, 1927, that I last saw her alive on February 13, 1927, and that death occurred, on the date stated above, at 830 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis and Arterial Hypertension

(duration) 3 yrs. 6 mos ds.

CONTRIBUTORY (Secondary): Apoplexy

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) [illegible], M. D.

2/17 1927 (Address) 8027 3 North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery

DATE OF BURIAL: 2/15 1927

20 UNDERTAKER: George J. Ruth

ADDRESS: 1735 Harford Ave

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19024

100-001 E 19024

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2217 E Biddle ST. 8-12 WARD)

2-FULL NAME John F. Donhauser

(a) RESIDENCE NO. 2217 E. Biddle ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~ Married, ~~Widowed, or Divorced~~ (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Josephine Donhauser.

6 DATE OF BIRTH (month, day, and year): May 3 1878

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 48 | 9 | 11 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lithographer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Fenn & Selden.

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Henry Donhauser

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Josephine Dudek

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Josephine Donhauser

(Address) 2217 E Biddle st

15 Filed FEB 15 1927, 19 C. HAMPSON JONES, M. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-14 1927

17 I HEREBY CERTIFY, That I attended deceased from 11-4, 1926, to 2/14, 1927.

that I last saw h[illegible] alive on 2-14, 1927.

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) David Riley, M. D.

2-14, 1927 (Address) 1500 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery

DATE OF BURIAL: Feb 16 1927

20 UNDERTAKER: Lemmon & Ruth

ADDRESS: 1300 Hanover

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

RAMOS

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19025

## CERTIFICATE OF DEATH.

89

E 19025

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4826 Park Heights Av ST. 27-56 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Nicholas Ramos

(a) RESIDENCE NO. 4826 Park Heights Av ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 47 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerical 089

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Joseph B Ramos

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cuba

12 MAIDEN NAME OF MOTHER Rebecca B Folly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Edna M. Ramos

(Address) 4826 Park Heights

15 Filed FEB 15 1927, 19 THOMPSON JONES, M. D.

Per Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 13 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan 31, 1927, to Feb 13, 1927

that I last saw him alive on Feb 12, 1927

and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas D Gilbert, M. D.

, 19 (Address) 4854 Park Heights Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Loudon Park | Feb 16 1927 |

20 UNDERTAKER ADDRESS

Geo Knull & Son 917 Wash Blvd

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

FR

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19026

## CERTIFICATE OF DEATH.

E 19026

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. 22-30 Ward)

2-FULL NAME Martin H. Fitzmorris

(a) RESIDENCE NO. Hoffman House St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1890

| 7 AGE | Years | Months | Days | IF LESS than 1 day ...hrs. or ...min. |
|---|---|---|---|---|
| | 37 36 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laigher

(b) General nature of indnstry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Martin Fitzmorris

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Annie ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant

(Address) Hospital Records

Filed FEB 15 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 February 13, 1927

17 I HEREBY CERTIFY, That I attended deceased from January 22, 1927, to February 13, 1927, that I last saw him alive on February 13, 1927, and that death occurred, on the date stated above, at 7.45 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. E. Sadtler, M. D.

2-14-27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem. Date of Burial Feby 16 1927

UNDERTAKER P. J. & E. Cowan Sons ADDRESS 701 Hollins St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 12-9-25—A Co.—200 Blks.

# E 19027

## HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 19027

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 19-24 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elliot Schuman

(a) RESIDENCE NO. 1321 E Pratt St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ½ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 5/23

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 3 | 4 | 10 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of indnstry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Hampton

(State or country) Va

PARENTS

10 NAME OF FATHER Jack Schuman

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Dora Abrahamson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Dora Schuman

(Address) 1321 E Pratt St

15 Filed FEB 15 1927, 19

C. HAMPSON JONES, M. D.

Per Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Feb 15, 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb 14, 1927, to Feb 15, 1927, that I last saw him alive on Feb 15, 1927, and that death occurred, on the date stated above, at 2.45 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Acute dysentery

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Max Rheinfeld, M. D.

4/15, 19 27 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale — Date of Burial: Feb 15 1927

20 UNDERTAKER: Lee Levinson & Bro — ADDRESS 1127 E Baltimore St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

Phelps

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19028

## CERTIFICATE OF DEATH.

E 19028

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor St. 10-14 Ward)

2-FULL NAME John Phelps

(a) RESIDENCE NO. Preston + Valley St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M. | W. | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 4th 1849

| 7 AGE Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|
| 77 | 3 | 10 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Edoran Phelps

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country)

12 MAIDEN NAME OF MOTHER Emily Francis

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country)

14 Informant Little Sisters of the Poor

(Address) Preston + Valley St.

Filed FEB 15 1927 C. HAMPSON JONES, M. D. Registrar

Per _____

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 27

Feb 14th

17

I HEREBY CERTIFY, That I attended deceased from No record 19 ..., to ..., 19 ...,

that I last saw h. alive on ..., 19 ...,

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Locomotor ataxia

ten years (duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. O'Connor, M. D.

Feb 14 1927 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Cath. — Date of Burial: 2/16 1927

20 UNDERTAKER: Geo. Auburn Son 2503 — ADDRESS: Edmondson ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 19029

E 19029
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 4092 Custer St. 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Geo. Hasbrook

(a) RESIDENCE NO. 4092 N Custer St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of): Bernadette Hasbrook

6 DATE OF BIRTH (month, day, and year): May 22 1871

7 AGE: Years 55 | Months 8 | Days 21 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Sheet Metal Worker
(b) General nature of industry, business, or establishment in which employed (or employer): 084
(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore
(State or country)

PARENTS

10 NAME OF FATHER: John A Hasbrook

11 BIRTHPLACE OF FATHER (city or town): Md
(State or country)

12 MAIDEN NAME OF MOTHER: Susanna Hellen

13 BIRTHPLACE OF MOTHER (city or town): Md
(State or country)

14 Informant: Bernadette Hasbrook
(Address): 4092 Custer

FEB 15 1927

C. HAMPSON JONES, M. D.
Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 13 - 1927

17 I HEREBY CERTIFY, That I attended deceased from May 1 1926 to Feb 13 1927, that I last saw h.....alive on Feb 13 1927, and that death occurred, on the date stated above, at 7A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach and Intestines

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Obstruction of Intestines

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 1927.

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edward J Geary M. D.

Feb. 19 27 (Address) 4237 N Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem. Date of Burial Feb 16 1927

20 UNDERTAKER: Lee M Funeral Home ADDRESS 911 N Wolfe

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

Wm Farr

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19030

## CERTIFICATE OF DEATH.

90 E 19030

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 19 N. Frederick ST., 47 WARD)

2-FULL NAME Park

(a) RESIDENCE NO. 19 N. Frederick ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | about 45 | | | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Lumber Piler
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant: John Park.
(Address)

15 Filed 192 Per Registrar

C. HAMPSON JONES, M. D.

FEB 15 1927

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6. 27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valv. dis. heart

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) (Coroner) M. D.

Feb 7. 192 (Address) 1039 Dan

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 192

UNDERTAKER

ADDRESS

JOHNS HOPKINS HOSPITAL

Deputy Commissioner of Health

FEB 15 1927

MORGUE

Union should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 1903I

E 1903F

REGISTERED NO. 57

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hotel St. 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edith Scher Behrman

(a) RESIDENCE NO. 1507 N. Appleton St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S. if of foreign birth 40 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| F | W | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Morris Behrman

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min.. |
|---|---|---|---|---|
| | 66 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER Solomon Scher

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Bella Shepard

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Jack Lewis

(Address) 1439 Eutaw St

15 Filed FEB 15 1927 19 C. HAMPSON JONES M. D. Registrar

per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/15 1927

17 I HEREBY CERTIFY, That I attended deceased from 2/13 1927, to 2/15 1927, that I last saw h[illegible] alive on 2/14 1927, and that death occurred, on the date stated above, at 12:30 P m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) 1 yrs. mos. ds.

18 Where was disease contracted ?

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine Examination

(Signed) John W. Graham, M. D.

19 (Address) 820 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Hebrew Friendship Cem. | 2/15 1927 |

20 UNDERTAKER Jack Lewis 1439 Eutaw St

ADDRESS

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS s[illegible] state C[illegible] OF DEATH in plain terms, so that it may be properly classified. Exact statement o[illegible] OCCUPATIO[illegible] very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 19032

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129 E 19032

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4052 Park Heights Ave. WARD) 15-58

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isaac abrams

(a) RESIDENCE No. 4052 Park Heights Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gertrude Abrams

6 DATE OF BIRTH (month, day, and year) Dec. 1864

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min |
|---|---|---|---|---|
| | 62 | 2 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

080

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Hale Abrams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Meyer Abrams
(Address) 4052 Park Heights Ave

15 Filed FEB 15 1927 C. HAMPSON JONES, M. D.
Registrar
Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/14 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 12th, 1926, to Feb 14th, 1927, that I last saw him alive on Feb. 14th, 1927 and that death occurred, on the date stated above, at 1030 P m

The CAUSE OF DEATH* was as follows:

Chronic Valvular heart disease

(duration) yrs. 2 mos 2 ds.

CONTRIBUTORY (Secondary) Chronic Interstial nephritis (duration) yrs. 2 mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Samuel Weinberg, M. D.

2/15 1927 (Address) 3735 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Hebrew Rest

DATE OF BURIAL 2/15 1927

UNDERTAKER D. Jack Lewis

ADDRESS 1439 E Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19033

## CERTIFICATE OF DEATH.

44

E 19033

REGISTERED NO.

1-PLACE OF DEATH Sinai Hosp

City of BALTIMORE: (No.) 4 N. St. 13-59 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Rothenberg

(a) RESIDENCE NO. 2416 Callow St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Marie Rothenberg

6 DATE OF BIRTH (month, day, and year): May 9 1873

7 AGE: Years 53 | Months 3 | Days 9 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Hungary

10 NAME OF FATHER Louis Brecker

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Hungary

12 MAIDEN NAME OF MOTHER Esther Hersker

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Hungary

PARENTS

14 Informant Mrs. R. Rothenberg

(Address) 2416 Callow Ave

Filed FEB 15 1927 C. HAMPSON JONES, M. D.

Per RK Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/13 1927

17 I HEREBY CERTIFY, That I attended deceased from 2/12 1927 to 2/13/27 19..., that I last saw h[illegible] alive on 2/13/27 19..., and that death occurred, on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows: Carcinoma of Splenic end of Stomach

(duration) ...yrs. 3 mos. 20 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) ...yrs. ...mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 2/7/27

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Emily Hamburger, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Friendship Cemetery Date of Burial Feb 17 1927

20 UNDERTAKER: D. Ahrens & Son ADDRESS 3314 Reisterstown Rd

Do not write in this space. Fill in carefully supplied. AGE Should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—1-12 23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19034

## CERTIFICATE OF DEATH.

100-001 E 19034

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1625 Jefferson St. 6-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlotte Yarborough.

(a) RESIDENCE No. 1625 Jefferson ST., ..... WARD

(Usual place of abode) (If non-resident give city or town and State)

length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | C | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) 1867

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 60 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Charlotte Perry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Henry Yarborough (Address) 1625 Jefferson.

15 Filed FEB 15 1927 C. HAMPTON JONES, M. D. Registrar

Per ____

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-14-27

17 I HEREBY CERTIFY, That I attended deceased from 2-11-, 1927, to 2-14-, 1927, that I last saw her alive on 2-13-, 1927, and that death occurred, on the date stated above, at 5.15 A.M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) ... yrs. — mos 7 ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Jos. H. Haggin, M. D.

2-15-1927 (Address) 611 N. Carey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Raleigh N C

DATE OF BURIAL Feb 15 1927

20 UNDERTAKER Robert Wilkins ADDRESS 1515 N. Eden St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

65-001

E 19035

## CERTIFICATE OF DEATH

E 19035

REGISTERED NO. 15-61

1-PLACE OF DEATH

City of BALTIMORE: (No.) 2103 Elsinor (St., or Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva Sproul Smith

(a) RESIDENCE NO. 2103 Elsinor Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. 10 mos. 29 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 16, 1880

| 7 AGE | Years | Months | Days | IF LESS than 1 day ...hrs. or ...min.. |
|---|---|---|---|---|
| | 46 | 10 | 29 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Art Needle Work

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer Smith & Fallon Balto.

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER James G. Smith

11 BIRTHPLACE OF FATHER (City or town) Devonshire

(State or country) England

12 MAIDEN NAME OF MOTHER Amelia Gardner

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Canada

14 Informant Mr. James Kerr Davis

(Address) 2103 Elsinor Ave.

15 Filed FEB 15 1927 19 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 14 19 27

17 I HEREBY CERTIFY, That I attended deceased from Dec- 2, 1926, to Feby- 14, 1927, that I last saw h[illegible] alive on Feby- 10, 1927, and that death occurred, on the date stated above, at 4- a. m.

The CAUSE OF DEATH* was as follows:

Cyrsome Lymphatic Leukaemia

(duration) 1- yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) Hayden Cell, M. D.

2/15 1927 (Address) 220 Harrison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cem

Date of Burial Feb. 17 1927

20 UNDERTAKER Wm. J. Rue & Son

ADDRESS North Pa

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 19036

# HEALTH DEPARTMENT—CITY OF BALTIMORE

86-001

## CERTIFICATE OF DEATH.

E 19036

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 102 W. Gibbons Ave ST., 27-41 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis E Morris

(a) RESIDENCE No. 102 W Gibbons Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred C yrs. 9 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 13th 1926

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs. or ....min. |
|---|---|---|---|---|
| | C | 9 | 1 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto City
(State or country)

PARENTS

10 NAME OF FATHER Frank Morris

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto City

12 MAIDEN NAME OF MOTHER Catherine Murphy

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Charles Co

14 Informant Mr Frank Morris
(Address) 102 W Gibbons Ave

15 FILED FEB 15 1927 C. HAMPSON JONES, M. D. Registrar
Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1st 1927 to Feb 14 1927.

That I last saw her alive on Feb. 14 1927

and that death occurred, on the date stated above, at 7.45 P. m.

The CAUSE OF DEATH* was as follows:

Pneumoc. Meningitis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Otitis Media

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Those of Meningitis

(Signed) Walter C Bacon M. D.

2/14 1927 (Address) 100 E 20th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem DATE OF BURIAL Feb 16 1927

20 UNDERTAKER Peter Nicolaus ADDRESS 2923 Eastern

BURIAL should be strictly supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Blks.

E 19037

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 19037

27-43

1-PLACE OF DEATH

REGISTERED NO._____

City of BALTIMORE: (No. 22 Bellewood Ave (Hamilton) St.) Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Winfield Keys

(a) RESIDENCE NO. 22 Bellewood Ave St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | widower |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Emma Keys

6 DATE OF BIRTH (month, day, and year) May 20-1850

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 76 | 8 | 23 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER James N. Keys

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Dorchester Co. Md.

12 MAIDEN NAME OF MOTHER Sarah Foxwell

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Dorchester Co., Md.

14 Informant Annie B. Lewis

(Address) 22 Bellewood Ave

15 Filed FEB 15 1927, 19__ C. HAMPSON JONES M. D. Registrar

By R.C.

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 13/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocardial Insufficiency

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) Senility

(duration) ___ yrs. ___ mos. ___ ds.

(Signed) J. H. Kelly M. D.

(Coroner)

2/14/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ___ yrs., ___ mos., ___ ds. In the State ___ yrs., ___ mos., ___ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery Date of Burial Feb 16 1927

20 UNDERTAKER Henry Lutz ADDRESS 1203 N. Broadway

This should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19038

## CERTIFICATE OF DEATH

REGISTERED NO. 75-001 E 19038

1-PLACE OF DEATH

City of BALTIMORE: (No. 3117 Dillon St., 1-L Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katharine Agnes Young.

(a) RESIDENCE NO. 3117 Dillon St. 1 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S. if of foreign birth yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Charles H. Young.

6 DATE OF BIRTH (month, day, and year) June 15 1850

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..hrs. or ..min.. |
|---|---|---|---|---|
| | 46 | 7 | 28 29 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 37

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) Boston Mass.

(State or country)

PARENTS

10 NAME OF FATHER James H. Kavanaugh

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ireland.

12 MAIDEN NAME OF MOTHER Della Bracken

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland.

14 Informant Charles H. Young (Husband)

(Address) 3117 Dillon St

Filed 1927 C. HAMPSON JONES, M. D.

Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 13th 1927

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1926, to Feb 13th, 1927.

that I last saw h[er] alive on Feb 13, 1927.

and that death occurred, on the date stated above, at 3.10 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

L. Hemiplegia

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) acute congestion of lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted Residence

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. L. Burke, M. D.

19 (Address) 3042 Hudson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — Date of Burial Feb 16 1927

20 UNDERTAKER Lilly + Zeller — ADDRESS 403 S. Wolfe St

Filed MAR 5 1927 Per

Registrar

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-357-A Co.—200 Bks.

2800 39

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

× 49 E 19039

E 19039

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vera Sparks

(a) RESIDENCE NO. New Freedom Pa St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1909

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 18 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Ind.

PARENTS

10 NAME OF FATHER Walter Sparks

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Ind.

12 MAIDEN NAME OF MOTHER Catherine Wilson

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Ind.

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

Filed FEB 15 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 Feb 15

17 I HEREBY CERTIFY, That I attended deceased from Feb 8 1927 to Feb 15 1927,

that I last saw h.. alive on Feb 15 1927,

and that death occurred, on the date stated above, at 11:10 A. m.

The CAUSE OF DEATH* was as follows:

Brain Tumor, Glioma (malignant)

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of 2/5/27

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) George E. Smith, M. D.

Feb 15, 1927 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pine Grove Cemetery Catonsville Balto Co Md Date of Burial Feb 18 1927

20 UNDERTAKER: Hartenstein Mortuary Md Line Md ADDRESS

15 1927

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 19040

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19040

## CERTIFICATE OF DEATH

31

1-PLACE OF DEATH

REGISTERED NO. 26-37

City of BALTIMORE: (No. 932 S. Third St. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Justina Beatrice Lillian Schulte

(a) RESIDENCE NO. 932 S. Third St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1901

| 7 AGE | Years | Months | Days | If LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 26 yrs | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerical

(b) General nature of industry, business, or establishment in which employed (or employer) work

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Joseph C. Schulte.

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Mary Andrews.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany.

14 Informant Mary B. Schulte.

(Address) 932 S. 3rd St.

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per ARR.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov, 1926, to Feb 12, 1927,

that I last saw her alive on Feb 11 1927,

and that death occurred, on the date stated above, at 6.15 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

about 2 (duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edward C. Whitman, M. D.

Feb 14, 1927 (Address) 5 E. Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Sacred Heart Cem. | Feb. 16th 1927 |

20 UNDERTAKER Lilly and Zeiler ADDRESS 403 S. Wolfe St.

If not stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AGE should be carefully supplied.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19041

10-10 19041

## CERTIFICATE OF DEATH.

REGISTERED NO. 77-43

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Tressa Forbes

(a) RESIDENCE No. 14 Orchard Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | white | single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 20, 1920

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 6 | 1 | 25 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer) at School

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Brooklyn N.Y.

PARENTS

10 NAME OF FATHER Robert Forbes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Durrell Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Nova Scotia

14 Informant Mrs. Robert Forbes

(Address) 14 Orchard ave

15 FEB 5 1927, 19 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb 14, 1927, to Feb. 14, 1927, that I last saw her alive on Feb. 14, 1927, and that death occurred, on the date stated above, at 7 30 p. m.

The CAUSE OF DEATH* was as follows:

Tons., Pharyn o Laryngeal Diphtheria

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Intubation Date of 2/14/27

Was there an autopsy? No

What test confirmed diagnosis? Clinical + pos. Kl culture

(Signed) Myron S. Tull, M. D.

2/15, 1927 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cmetery DATE OF BURIAL Feb. 16 1927

20 UNDERTAKER Fredk Loeffler & Sons ADDRESS Fulton

CAUSE OF DEATH must be plainly written, so that it may be properly classified. See instructions on back of certificates.

1

Spec.—12-27—X C5—200 Bks.

1927 E 19042

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

× 159 E 19042

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob-Homer Simmers

(a) RESIDENCE NO. Penn Laird St. Va Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1923

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 4 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 60

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Va -

PARENTS

10 NAME OF FATHER Jacob Simmers

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Sybil Cunningham

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va -

14 Informant JOHNS HOPKINS Records

(Address) JOHNS HOPKINS HOSPITAL

FEB 15 1927 C. HAMPSON JONES, M. D. Registrar

Par

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 15 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan 25 1927, to Feb 15 1927,

that I last saw alive on Feb 15 1927,

and that death occurred, on the date stated above, at 2:25 P m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of Feb 15 1927

Was there an autopsy? No

What test confirmed diagnosis? Operation & Examination

(Signed) George E. Shinn, M. D.

2/17/27 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Elkton Md | 2/15/27 |
| 20 UNDERTAKER | ADDRESS |
| Joseph Ahern | 721 Ry |

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19043 .46 E 19043

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1143 N Carrollton ST. 16-22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME May Robinson

(a) RESIDENCE NO. 1143 N Carrollton ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Leonard Robinson

6 DATE OF BIRTH (month, day, and year): Sept. 15, 1881

7 AGE — Years: 45 Months: 4 Days: 28 If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stf. — 037

(b) General nature of Industry, business, or establishment in which employed (or employer): Housekeeper.

(c) Name of employer: Self.

9 BIRTHPLACE (city or town) (State or country): Chestertown Md Baltimore Co.

PARENTS

10 NAME OF FATHER: Isaiah Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Co.

12 MAIDEN NAME OF MOTHER: Julia Painter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Co

14 Informant: Jessie V Taylor

(Address): 553 Lanvale St

15 Filed: 5 1927

Registrar: C. HAMPSON JONES, M.D.

Rec'r: ARL

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 13 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 9, 1927, to Feb 13, 1927, that I last saw her alive on Feb 13, 1927, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Uterine Carcinoma

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Rt Bronch. Pneumonia & Hypo

Age Cancer (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? c

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) W A Wright, M. D.

Feb 13, 1927 (Address) 1209 Eastman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: M Auburn — DATE OF BURIAL: Feb 16 1927

20 UNDERTAKER: Samuel McCausland — ADDRESS: 1400 Madison

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

# E 19044

## HEALTH DEPARTMENT—CITY OF BALTIMORE

~~BIRTH NO.~~ 16-002 ~~E 19044~~

### CERTIFICATE OF DEATH.

Registered No. .....

1-PLACE OF DEATH University Hospital

City of BALTIMORE: (No. Lombard St. Ward) 16-27

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Carter

(a) Residence No. 1104 N. Stricker St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

| 3-SEX. | 4-COLOR OR RACE. | 5-Single, Married, Widowed, or Divorced. (Write the word.) |
|---|---|---|
| Male | Colored | |

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 2 9 27

7-AGE. 0 yrs. mos. ds. If LESS than 1 day, hrs. or 40 min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Simon Carter

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Ernestine Carter

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Virginia

14- (Informant)

(Address)

15- Filed, 1927 C. HAMPSON JONES, M. D. Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 2-9-27

17- I HEREBY CERTIFY, That I attended deceased from 2-9-1927 to 2-9-1927

that I last saw h[illegible] alive on 2-9-1927

and that death occurred, on the date stated above, at 2:15 a/a M.

The CAUSE OF DEATH* was as follows:

Prolonged labor

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Congenital atelectasis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Grafton Dodge, M. D.

, 19 (Address) University Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

| 19-PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL. ..... 19.... |
|---|---|
| 20-UNDERTAKER, | ADDRESS |

DEC 5 1927 UNIVERSITY OF MARYLAND

UNIVERSITY OF MARYLAND

If plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Matthews

# E 19045 HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 E 19045

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1622 W. Lo. Ave (ST.) 14-70 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Matthews

(a) RESIDENCE NO. 1622 W. Lo. Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: — 1867

6 DATE OF BIRTH (month, day, and year): 1870

7 AGE: 60 Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Waiter 10

(b) General nature of industry, business, or establishment in which employed (or employer): Hotels

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Frederick Matthews

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Mary Graham

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Rebecca Graham 30 Poplar Grove

15 Filed 8 16 1927, 19 C. HAMPSON JONES, M. D. Registrar

Per R.F.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 14th 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1927 to Feb. 14th 1927

that I last saw him alive on Feb. 13th 1927

and that death occurred, on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows: Lobar Pneumonia

CONTRIBUTOR (Secondary): Valvular Disease (duration) 3 yrs. mos. ds.

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) R. Lee Tyler, M. D.

19 , 19 (Address) 922 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: 2-16 1927

20 UNDERTAKER: John H. Tradum — ADDRESS: 1027 Druid Hill

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

19046

## CERTIFICATE OF DEATH

21-24

100 E 19046

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. South Baltimore Gen. Hospital St. Ward)

2-FULL NAME Mrs. Susan R. Collins

(a) RESIDENCE NO. 751 McHenry St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: White

5. Single, Married, Widowed, or Divorced, (write the word): Widowed

3a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles E. Collins

6 DATE OF BIRTH (month, day, and year): January 25th 1841

7 AGE: Years: 86 years; Months: XXX; Days: 20; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Frederick

(State or country): Maryland

PARENTS

10 NAME OF FATHER: David F. Smith

11 BIRTHPLACE OF FATHER (city or town): Frederick

(State or country): Maryland.

12 MAIDEN NAME OF MOTHER: Susan E. Ford

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): St. Marys Co., Md.

14 Informant: Thomas H. Smith

(Address) 723 Linwood Ave. Roland Pk.

15 Filed FEB 16 1927 C. HAMPSON JONES, M. D. Registrar

Per RC

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Feb 14th 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb 9th, 1927, to Feb 14th, 1927

that I last saw h.... alive on 14th of Feb, 1927,

and that death occurred, on the date stated above, at 2.30 P.m.

The CAUSE OF DEATH* was as follows:

Basal Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Infected Lungs.

(duration) yrs. mos. 6 ds.

18 Where was disease contracted

If not at place of death? At Home

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Blood Count.

(Signed) H. H. Miller, M. D.

2/14 1927 (Address) So Balto Gen. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

Date of Burial: Feb. 17 1927

20 UNDERTAKER: Joseph B. Cook

ADDRESS: 1003 W. Balto St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19047

E 19047

CERTIFICATE OF DEATH

16-68 101-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2801 Walbrook Ave. WARD)

2-FULL NAME Helen C. Gerben

(a) RESIDENCE NO. 2801 Walbrook Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~life~~ mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles A. Gerben

6 DATE OF BIRTH (month, day, and year) April 3, 1896

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 30 | 10 | 11 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Littlestown
(State or country) Penna.

PARENTS

10 NAME OF FATHER Jon A. Auman

11 BIRTHPLACE OF FATHER (city or town) Hanover
(State or country) Penna.

12 MAIDEN NAME OF MOTHER Lucy King

13 BIRTHPLACE OF MOTHER (city or town) Littlestown
(State or country) Penna.

14 Informant Charles A. Gerben Jr.
(Address) 2801 Walbrook Avenue

15 Filed FEB 16 1927 HAMPSON JONES, M. D. Registrar
Per

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 14 1927

17 I HEREBY CERTIFY, That I attended deceased from July. 4 1927 to July 14 1927.

that I last saw her alive on July 14 1927

and that death occurred, on the date stated above, at 11.30 a.m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia, Entire Lft side.

(duration) — yrs. — mos 6 ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical signs

(Signed) [illegible] M. D.

2-14 1927 (Address) 2100 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL Feb. 16 27

20 UNDERTAKER Joseph B Cook

ADDRESS 1003 N. Carey St

mation should be carefully supplied. Avoid abbreviations. Write clearly in ink. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19048

## CERTIFICATE OF DEATH.

31 E 19048

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) Baltimore City Hospitals (7-13) St. (Ward)

2-FULL NAME August Wise (Weis )

(a) RESIDENCE NO. 1631 Eager st. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary Wise

6 DATE OF BIRTH (month, day, and year) 1876

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| 51 | 50 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Andrew Weist

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Pecht

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Hospital Records

(Address)

Filed FEB 16 1927, 19

C. HAMPSON JONES, M. D.

Registrar

Per

EB 16 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

February 15, 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb. 11, 1927, to Feb. 15, 1927,

that I last saw him alive on Feb. 15, 1927,

and that death occurred, on the date stated above, at 1.30 P.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes Autopsy

What test confirmed diagnosis?

(Signed) J. E. Gadsden, M. D.

2-15-27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Holy Redeemer Cemetery Feb. 18 1927

20 UNDERTAKER — ADDRESS

Henry Hoeck Son 1301 E Eager St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

202 ✓

E 19049

1-PLACE OF DEATH

E 19049

REGISTERED NO._____

City of BALTIMORE: (No. 1612 Jackson St. 24-34 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Frick.

(a) RESIDENCE NO. 1521 Marshall St. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. 0 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female. | White. | Married. |

5a If married, widowed, or divorced, (or) WIFE of Phillip Frick.

6 DATE OF BIRTH (month, day, and year) February 3, 1854.

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 73 | 0 | 10 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER William Barnes.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Anna Riddle.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany.

14 Informant Phillip Frick. (husband)

(Address) 1521 Marshall St.

15 FILED FEB 16 1927 C. HAMPSON JONES, M. D. Registrar

Rec'r _____

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feoruary 13, 1927 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Knocked down by and under a fence by the accidental falling of the same, shock Mitral regurgitation. Acute dilatation of the heart. (duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs. .....mos. .....ds.

(Signed) Otto M. Eisenhardt M. D.

(Coroner)

2/14 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Accident in rear of 1615 Bell St.

Feb. 8, 1927.

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem. Date of Burial 2-16 1927

20 UNDERTAKER Ernest B Hale ADDRESS 1152 West St

Be sure every question is answered. Note should be taken that CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19050

## CERTIFICATE OF DEATH.

129 E 19050

REGISTERED NO.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St. 19-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Felicia Howard

(a) RESIDENCE NO. 509 N. Norris St. Ward

(Usual place of abode) ?

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ?

6 DATE OF BIRTH (month, day, and year) 1887

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 40 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country) Virginia

PARENTS

10 NAME OF FATHER Fleming Jackson

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Va

12 MAIDEN NAME OF MOTHER Rose Gibson

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Va

14 Informant

(Address) Records

C. HAMPSON JONES, M. D.

Filed ..... 19 Registrar

FEB 16 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 13 1927

17

I HEREBY CERTIFY, That I attended deceased from February 7 1927, to February 13, 1927, that I last saw h[illegible] alive on February 13, 1927, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Hypertension

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Haemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? general & laboratory

(Signed) R. Hooper Smith, M. D.

Feb 17 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery — Date of Burial: Feb 17, 1927

20 UNDERTAKER: Mrs Katie R. Williams — ADDRESS 322 N. Schroeder St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co.—1000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19051

## CERTIFICATE OF DEATH.

101-001

E 19051

REGISTERED NO.

1-PLACE OF DEATH 806 S Sharp St

CITY OF BALTIMORE: (No. Baltimore St. 93-31 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amanda Young

(a) RESIDENCE. No. 806 S Sharp St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs mos ds

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| female | colored | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Arthur Young

6 DATE OF BIRTH (month, day, and year) April 9, 1880

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| 47 | 46 | 10 | 3 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home-wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Zanesville, Ohio

PARENTS

10 NAME OF FATHER Lewis White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Zanesville Ohio

12 MAIDEN NAME OF MOTHER Jane

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Zanesville Ohio

14 Informant Arthur Young
(Address) 806 S Sharp St

15 Filed FEB 16 1927 C. HAMPSON JONES, M. D. Registrar
By R.M.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 12 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 7 1927 to Feb 12 1927

that I last saw her alive on Feb 12 1927

and that death occurred, on the date stated above, at 1,30 p. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. 0 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. H. Jones M. D.

2/16/1927 (Address) 1128 Sharp Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Mt. Auburn Cemetery | Feb. 16, 1927 |
| 20 UNDERTAKER | ADDRESS 322 |
| Mrs. Katie R. Williams | N. Schroeder St |

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19052

## CERTIFICATE OF DEATH.

74-001

E 19052

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hosp. St. 16-23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Oscar Bommeller

(a) RESIDENCE NO. 927 St. N Caren Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE: Years 56 Months Days IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Mechanic

(c) Name of employer: Pollett Harvey

9 BIRTHPLACE (city or town): Balto

(State or country)

PARENTS

10 NAME OF FATHER: Oscar D. Bommeller

11 BIRTHPLACE OF FATHER (city or town): Germany

(State or country)

12 MAIDEN NAME OF MOTHER: Mary Warner

13 BIRTHPLACE OF MOTHER (city or town): Ireland

(State or country)

14 Informant: Mrs Gw. Bommeller

(Address): Towson.

15 Filed FEB 16 1927 C. HAMPSON JONES, M. D. Registrar

Per: [illegible]

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Feb 11th 27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

Sudden (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. F. Luby M. D.

(Coroner)

Feb 15th, 19 27 (Address) 1029 Bennett Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ..... mos., ..... ds. In the State ..... yrs., ..... mos., ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park. Date of Burial: Feb. 16 1927

20 UNDERTAKER: Wm Cook ADDRESS: 507 E. North

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 19053 — REGISTERED NO. E 19053

1-PLACE OF DEATH

City of BALTIMORE: (No. 5 Krebs Ave. St., Not Worked out Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Price

(a) RESIDENCE NO. 5 S Krebs Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Naomi Price

6 DATE OF BIRTH (month, day, and year): Aug 29. 1863

7 AGE — Years: 63 Months: 5 Days: 15 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Supt

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Boys Home Society

9 BIRTHPLACE (city or town): Balto

(State or country): Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (City or town): Unknown

(State or country)

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): Unknown

(State or country)

14 Informant: Geo. M Tucker

(Address): 5 Krebs Ave

15 Filed ..... 19..... C. HAMPTON JONES, M. D. Registrar

Per .....

FEB 16 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 11 1927

17 I HEREBY CERTIFY, That I attended deceased from July 1st, 1926, to Feb 14, 1927, that I last saw h.. alive on Feb 14, 1927, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cancer of Tongue

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary): None

(duration) yrs. mos. ds.

18 Where was disease contracted: Home

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Diagnosis

(Signed) W. W. Peaine, M. D.

2-15-1927 (Address) 18 Paul & Preston Sts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore — Date of Burial: Feb 17 1927

20 UNDERTAKER: H. C. Cook — ADDRESS: 502 E Monument

IT IS THE DUTY of Attending Physicians, Midwives and Undertakers to see that a CERTIFICATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19054

## CERTIFICATE OF DEATH.

101-001 E 19054

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 332 Patapsco ave St. Helena 26-36 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michal Pryczka

(a) RESIDENCE. No. 332 Patapsco ave, ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. 7 mos. 9 ds. How long in U. S., if of foreign birth? 14 yrs. — mos. — ds.

(If nonresident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | W. | Married |

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Anna Pryczka

6 DATE OF BIRTH (month, day, and year) 1880

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs. or ....mins. |
|---|---|---|---|---|
| | 47 | 4/6 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Moulder

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Central Foundry Co.

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER John Pryczka

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Mahmone

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Mary Pryczka (Address) 332 Patapsco ave

15 Filed ....., 19 C. HAMPSON JONES, M. D. Registrar

Per

FEB 16 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 13, 1927, to Feb 14, 1927, that I last saw h.. alive on Feb 14, 1927, and that death occurred, on the date stated above, at 10-30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A. Kuhn M. D.

2/14 1927 (Address) Dundalk Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| St Stanislaus | Feb 16 1927 |

20 UNDERTAKER Wm Cook — ADDRESS 502 Hanover

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26–A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

# CERTIFICATE OF DEATH

E 19055

E 19055

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 318 S. Garrison Lane St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alverta Frey.

(a) RESIDENCE NO. 318 S. Garrison Lane St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry T Frey

6 DATE OF BIRTH (month, day, and year): Sept 19. 1857

7 AGE Years: 69 Months: 4 Days: 25 IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Geo. J Mortier

11 BIRTHPLACE OF FATHER (City or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Sarah Chapman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Mrs Lottie Frey

(Address) 318 S. Garrison Lane

15 Filed FEB 16 1927 H. HAMPSON JONES, M. D. Registrar

Ref

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14 1927

17 I HEREBY CERTIFY, That I attended deceased from 2. 8, 1927, to 2. 14. 27, 19..., that I last saw h.. alive on 2. 14. 27, 19..., and that death occurred, on the date stated above, at 7.15 P m.

The CAUSE OF DEATH* was as follows:

(a) Lobar pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no What test confirmed diagnosis? Physical findings

(Signed) J Edward Norris, M. D.

2.15, 1927. (Address) 107 Eastwest Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — Date of Burial Feb. 17 1927

20 UNDERTAKER H. C. Cook — ADDRESS 502 E Fayette

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19056

## CERTIFICATE OF DEATH.

E 19056

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 135 N. Montford av. St., 6-10 WARD)

2-FULL NAME William Tiink

(a) RESIDENCE NO. 135 N. Montford av. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., If of foreign birth? 58 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fredrika Tiink

6 DATE OF BIRTH (month, day, and year) Feb 8 1861

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs. or min. |
|---|---|---|---|---|
| | 66 | | 5 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Cent. Con. Co.

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Jacob Tiink

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margret Holm

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Henry Tiink

(Address) 135 N. Montford av

Filed FEB 16 1927 C. HAMPTON JONES, M. D.

Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 13 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1927, to Feb 13, 1927, that I last saw him alive on Feb 13, 1927 and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Ernest L. Green M. D.

2-15, 1927 (Address) 120 Argyle St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery DATE OF BURIAL Feb 16 1927

UNDERTAKER Chas C. Miller & Son ADDRESS 2534 Eastern av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

99-602

E 19057

## CERTIFICATE OF DEATH.

E 19057

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 813 Pennsylvania Ave ST. 17-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Dwyer

(a) RESIDENCE NO. 813 Pennsylvania Ave., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. — mos. — ds. How long in U. S., if of foreign birth? 80 yrs. — mos. — ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lysenus V. Dwyer

6 DATE OF BIRTH (month, day, and year) June 12 1841

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs or min. |
|---|---|---|---|---|
| | 85 | 8 | 3 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant William A Kerns

(Address) 813 Pennsylvania Ave

15 Filed B 16 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15th 1927

17

I HEREBY CERTIFY, That I attended deceased from January 27 1927 to July 15th 1927.

that I last saw him alive on July 13 1927.

and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Catarrhal Bronchitis and Pneumonia (duration) — yrs. — mos. 18 ds.

CONTRIBUTORY (Secondary) Exhaustion Weakness (duration) — yrs. — mos. 18 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Edward E Mackenzie M. D.

July 15, 1927 (Address) 1330 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem. | DATE OF BURIAL: 7/17 1927

20 UNDERTAKER: John J Fields | ADDRESS: 1200 W Lombard

CAUSE OF DEATH to plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

19058

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

101-001

E 19058

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 911 Shutter St., 7-13 WARD)

2-FULL NAME John W. Johnson

(a) RESIDENCE NO. 94 Shutter ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. 23 mos. ds. How long in U. S., if of foreign birth? yrs. mos ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Della Johnson

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE: Years: about 54 | Months: — | Days: — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer Gd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Texas Md.

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Laura Johnson (Wife) 94 Shutter St

15 Filed FEB 16 1927 Registrar H. HAMPSON JONES, M. D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 8, 1927, to Feb 14, 1927, that I last saw him alive on Feb 14, 1927, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) R J Young, M. D.

2/14 1927 (Address) 149 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Orbans Cemetery — DATE OF BURIAL: Feb 17 1927

UNDERTAKER: John H Owens — ADDRESS: 538 Dolphin St

CAUSE OF DEATH to be given in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 19059

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

179 E 19059

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital 15-65 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Doris Lebarwitz

(a) RESIDENCE NO. 4012 Baltimore Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 6, 1919

7 AGE — Years: 7 Months: 10 Days: 9 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Balto.

(State or country): Md.

PARENTS

10 NAME OF FATHER: Louis L. Lebarwitz

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Russia

12 MAIDEN NAME OF MOTHER: Rose Jacobs

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Balto. Md.

14 Informant: E. Crockin

(Address): 29 Hopkins Place.

FEB 16 1927

C. HAMPSON JONES, M. D.

Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/15/1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Burns over entire body- Clothes caught fire while she was playing with matches.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) J. J. Pace M. D.

(Coroner)

2/16/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ..... mos., ..... ds. In the State ..... yrs., ..... mos., ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship — Date of Burial: 2/16/1927

20 UNDERTAKER: David Sonnheim — ADDRESS: 1420 W. Mt. Royal Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 1-10-21 M&T 1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19060

## CERTIFICATE OF DEATH.

164 E 19060

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 12 North Callington Ave. WARD) 6-10

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ann Charlotte Pappler

(a) RESIDENCE NO. 12 North Callington Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 21 - 1844

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 82 | 4 | 23 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER George W. Pappler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Elizabeth P. Slater

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Roberta L. Wheler

(Address) 12 N. Callington Ave

15 Filed FEB 16 1927 C. HAMPSON JONES, M. D. Registrar

Per —

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 4, 1927, to Feb 14, 1927, that I last saw h[illegible] alive on Feb 13, 1927, and that death occurred, on the date stated above, at 7 A — m.

The CAUSE OF DEATH* was as follows:

General Debility

6 Mths (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Age — (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) N. L. Daclucca M. D.

, 19 (Address) 2927 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Greenmount Cemetery | Feb 17 1927 |
| 20 UNDERTAKER | ADDRESS |
| Pyfer & Sons | 424 N Broadway |

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-27—C6.—200 Bks.

1927.4

E 19061

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

161-001

E 19061

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 19-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Long

(a) RESIDENCE NO. 337 Bruce St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced. (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 1, 1927

7 AGE: Years 3 wks | Months 1 | Days 14 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: nil

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Md.

PARENTS

10 NAME OF FATHER Thomas Long

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Md.

12 MAIDEN NAME OF MOTHER Stella Thomas

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Md.

14 Informant: Parents.

(Address) JOHNS HOPKINS HOSPITAL

Filed FEB 16 1927, 19 C. HAMPSON JONES, M. D. Registrar

Per R.R.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 Feb. 16

17 I HEREBY CERTIFY, That I attended deceased from Jan 21, 1927, to Feb 16, 1927, that I last saw h.e alive on Feb 16, 1927, and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Prematurity.

(duration) Life hrs. mos. ds.

CONTRIBUTORY (Secondary) Malnutrition.

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. E. Handley, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem Date of Burial Feb 16th 1927

20 UNDERTAKER: A. Jones ADDRESS 1118 Gilmor

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19062

E 19062

1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

170

Registered No. C.....

City of BALTIMORE: (No. 3508 Hickory Ave. St., 13 52 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry L. Fisher

(Residence in Baltimore: No. 3508 Hickory Ave. Sts.) 43 yrs. ..... mos. ..... ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

| 3-SEX | 4-COLOR OR RACE | 5-Single, Married, Widowed, or Divorced. (Write the word.) |
|---|---|---|
| Male | White | Single |

6-DATE OF BIRTH. Nov. 22- 1883
(Month) (Day) (Year)

7-AGE. 39 yrs. 2 mos. 23 ds. If LESS than 1 day, ....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... 019
(b) General nature of industry, business, or establishment in which employed (or employer) Cigars & Confectionery 019

9-BIRTHPLACE, (State or Country) Carroll Co. Md.

PARENTS.

10-NAME OF FATHER Charles H. Fisher

11-BIRTHPLACE OF FATHER, (State or Country) Maryland

12-MAIDEN NAME OF MOTHER, Mary A. Lashine

13-BIRTHPLACE OF MOTHER, (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary A. Fisher

(Address) 3508 Hickory Ave.

15- FEB 16 1927 J. HAMPSON JONES, M. D.

Registrar.

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 14 1927
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or Inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Gun Shot Wound
Through Heart
Suicide

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. H. Morrison M. D.
(Coroner)

2/15 1927 (Address) 1632 Roland Ave

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL St. Mary's Hampden DATE OF BURIAL. Feb. 17 1927

20-UNDERTAKER Horace A. Burgee ADDRESS 3631 Falls Rd

is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 19063

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

57 E 19063

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St. 15-58 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Sallie Permar.

(a) RESIDENCE NO. 2906 Kate Ave. City St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: William P. Permar

6 DATE OF BIRTH (month, day, and year): July 5-1868

7 AGE: Years 58 Months 6 Days 29

IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Anne Hill, Md

(State or country)

PARENTS

10 NAME OF FATHER: Jacob Sturgis

11 BIRTHPLACE OF FATHER (City or town): Md.

(State or country)

12 MAIDEN NAME OF MOTHER: Mary Bratton.

13 BIRTHPLACE OF MOTHER (city or town): Md

(State or country)

14 Informant: Mrs. Florence Permar

(Address) 2906 Kate Ave. City

FEB 16 1927

HAMPSON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927

2-14-

17 I HEREBY CERTIFY, That I attended deceased from 2-9, 1927, to 2-14, 1927,

that I last saw her alive on 2-14, 1927,

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertonic Hypertension

(duration) 1 yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical & Lab. Exam.

(Signed) W P McBride, M. D.

, 19 (Address) 2-14-27

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn

Date of Burial: Feb. 17 1927

20 UNDERTAKER: Horace H. Burns

ADDRESS: 3[illegible]

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19064

## CERTIFICATE OF DEATH.

E 19064

REGISTERED NO. 7

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 419 N. Central av ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gloria Norman

(a) RESIDENCE NO. 419 N. Central av ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Colored | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 24 1924

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or min. |
|---|---|---|---|---|
| | 3 | | 20. | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER Jno Norman

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Jane T Frazier

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Hattie T Frazier
(Address) 419 N. Central av

15 Filed ....., 19.... C. HAMPSON JONES, M. D. Registrar

B 16 1927 Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 14, 1927, to Feb 14, 1927.

that I last saw h[illegible] alive on Feb 14, 1927

and that death occurred, on the date stated above, at 3.25 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Probably Measles

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Robert H Green M. D.

2-15, 1927 (Address) 170 Virginia Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Laurel cemetery | Feb 17 1927 |
| 20 UNDERTAKER | ADDRESS 1681 |
| Edward Bowyan | orleans St |

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19065

## CERTIFICATE OF DEATH.

21 E 19065

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 410 Evesham Ave St. 27-48 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Beauregard MacDonald

(a) Residence No. 410 Evesham Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, ~~Widowed~~, or Divorced (write which word): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Minnie Pampell MacD

6-DATE OF BIRTH (month, day and year): Dec. 24, 1865

7-AGE: 61 yrs. 1 mos. 18 ds. If LESS than 1 day, ....hrs. or.....min.? 20

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer): Banking

(c) Name of employer: Fidelity Trust Co

9-BIRTHPLACE (city or town) (State or Country): Balto. Md.

PARENTS:

10-NAME OF FATHER: George MacDonald

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Balto Md.

12-MAIDEN NAME OF MOTHER: B. Pilfah

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balto Co

14- (Informant): Mrs. G. Fink

(Address): 410 Evesham Ave

15- (Date received): FEB 16 1927

C. HAMPSON JONES, M. D. Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Feb 14, 1927

17- I HEREBY CERTIFY, That I attended deceased from Feb 11 1927 to Feb 14 1927.

that I last saw h.. alive on Feb 14 1927.

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Erysipelas of face following perforation of nose

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary): Bronchopneumonia - Septic

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) G. L. Bishop M. D.

Feb 15, 1927 (Address) 501 Sheridan Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loraine Cem

DATE OF BURIAL: 2/16/27 19....

20-UNDERTAKER: Mary M. Wiedefeld

ADDRESS: 512 E. 22 St.

Instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

(E 264) E 19066

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

X 131

REGISTERED No. E 19066

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ) ST., 79 WARD)

2-FULL NAME Mrs. Agnes Hickson (Mrs. C.)

(a) RESIDENCE No. 305 N.E. 21 St. Miami-Dade ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 16 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | married |

5a If married, widowed, or divorced (or) WIFE of Cecil Hickson

6 DATE OF BIRTH (month, day, and year) ~~Unknown~~

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min |
|---|---|---|---|---|
| | 39 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Florida

PARENTS

10 NAME OF FATHER Melville Sligh

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Lila Durant

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Records JOHNS HOPKINS HOSPITAL (Address)

Filed FEB 16 1927 C. HAMPSON JONES, M. D. Registrar

Per VRR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 16 1927.

17 I HEREBY CERTIFY, That I attended deceased from Jan. 31, 1927, to Feb. 16, 1927.

that I last saw her alive on Feb. 16, 1927

and that death occurred, on the date stated above, at 9:50 a m

The CAUSE OF DEATH* was as follows:

Pyelo-nephritis, bilateral

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Johns Hopkins Hospital

Did an operation precede death? Yes Date of Feb. 8 -

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Eldembrang M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Miami, Fla. DATE OF BURIAL Feb. 16 1927

20 UNDERTAKER John A. Mitchell ADDRESS 1900 Eutaw Pl.

TION IS very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19067

## CERTIFICATE OF DEATH.

188-003

REGISTERED NO. E 19067

1-PLACE OF DEATH University Hospital

City of BALTIMORE: (No. ~~621 W Lombard~~ St. 17-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jeannette Fitzsimmons

(a) RESIDENCE NO. 621 W Lombard St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | Col. | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 25 1918

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 7 | 6 | 16, 15 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balt

(State or country)

PARENTS

10 NAME OF FATHER Herman Wilson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Emily Johnson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balt

14 Informant Evelyn Johnson

(Address) 1034 Argyle Ave.

15 Filed FEB 10 1926, 19 HARRISON JONES, M. D.

Per Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/7/ 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Instantaneously accidental

Fractured ~~mastoid~~ temporal bone

while crossing street.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fractured left leg

(duration) yrs. mos. ds.

(Signed) Edward J. Gorman M. D.

(Coroner)

, 19 27 (Address) 620 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem Date of Burial 2/9/ 192 7

20 UNDERTAKER Samuel Brumley ADDRESS 2 W Fayette St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19068

## CERTIFICATE OF DEATH.

84 E 19068

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 551 Boyd St. 18-16 Ward)

2-FULL NAME Louis Boyer

(a) RESIDENCE NO. 551 Boyd St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Louis Boyer

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE: Years 71 Months Days

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Private

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country)

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) Not Known

(State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known

(State or country)

14 Informant Louis Boyer

(Address) 887 Boyd

15 Filed ..... 19.....

(C. HAMILTON JONES, M. D.) Registrar

RRM

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1925

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

[illegible]

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner)

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Date of Burial 2/16 1925

20 UNDERTAKER Samuel Kemsley ADDRESS 578 N Bdle

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19069

## CERTIFICATE OF DEATH.

90 E 19069

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1531 N. Smallwood ST. 15-68 WARD)

2-FULL NAME Benj. Kosnesky

(a) RESIDENCE NO. 1531 N. Smallwood ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | white | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Kosnesky

6 DATE OF BIRTH (month, day, and year) c 1875

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 52 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) 880

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Isaac Kvonesky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Levi

(Address) 4329 Baltimore St

Filed FEB 16 1927

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-16-1927

17 I HEREBY CERTIFY, That I attended deceased from July, 1925, to Feb 15, 1927, that I last saw h[illegible] alive on Feb 15, 1927 and that death occurred, on the date stated above, at 4 G - m

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Hypertension

Myocardial degeneration

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M S Goldstein, M. D.

2/16 1927 (Address) 1516 N Bentalou st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Hebrew Rosedale | 2/16 1927 |

20 UNDERTAKER ADDRESS

Jack Levi 4329 Baltimore

How is very important. See instructions on back of certificate.

Cor.—12-9-25—4 Co.—200 Bks.

E 19070

May Sofin

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 19070

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mt Royal Hotel St. 11-19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mark Sofin

(a) RESIDENCE NO. 40 Chicago St. Ward Chicago

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1879

7 AGE: Years 48 Months Days

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Singer

(b) General nature of industry, business, or establishment in which employed (or employer): Operator

(c) Name of employer

9 BIRTHPLACE (city or town): Russia

(State or country)

PARENTS

10 NAME OF FATHER: Leib. Sofin

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Russia

12 MAIDEN NAME OF MOTHER: Sara Rotenberg

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Russia

14 Informant: Sam Sofin

(Address): New Brunswick, N.J.

FEB 16 1927 C. HAMPSON JONES, M. D.

Filed For CHJ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to (his) death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Accident? (duration) 0 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) H. C. Yaksey M. D.

(Coroner)

Feb 16, 1927 (Address) 1639 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Detroit Mich

Date of Burial: Feb 16 1927

20 UNDERTAKER: Jack Lewis

ADDRESS: 1439 Eastern

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

DEATHS in public institutions, or those in any way improperly classified.

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19071 CERTIFICATE OF DEATH. X 129 E 19071

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 41 So 11th St (ST.) 26-37 (WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma J Spanwasser

(a) RESIDENCE NO. 41 So 11th St ST., WARD Balto Co. Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced (or) WIFE of Henry C Spanwasser Decd

6 DATE OF BIRTH (month, day, and year) July 30 1856

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 70 | 6 | 14 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Jermia D. Baily

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Elizabeth Detwiller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Thos Geo Spanwasser, (Address) 41 So 11th St

15 Filed FEB 16 1927, 19 C. HAMPSON JONES, M. D. Registrar Per RRA

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 16 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1926, to Feb 16, 1927, that I last saw her alive on Feb 16, 1927, and that death occurred, on the date stated above, at 10P m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Pneumonia Influenza (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. L. Mazer, M. D.

2/16, 1927 (Address) 261 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dust Ridge DATE OF BURIAL Feb 17 1927

UNDERTAKER W S Marshall ADDRESS 3538 Wilkens Ave

TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

99-001

E 19072

## CERTIFICATE OF DEATH.

E 19072

1-PLACE OF DEATH

24-34

REGISTERED NO.

City of BALTIMORE: (No. 819 E. FORT AVE. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Robey.

(a) RESIDENCE NO. 812 E. FORT AVE. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 11 mos. 29 How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male, | White, | Single. |

3a If married, widowed, or divorced HUSBAND of (or) WIFE of infant.

6 DATE OF BIRTH (month, day, and year) Feb. 17, 1926

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | | 11, | 29. | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Frank Robey.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) N. J.

12 MAIDEN NAME OF MOTHER Irma Cameron

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va.

14 Informant Frank Robey, (Father).

(Address) 819 E. FORT AVE.

15 Filed....., 19

C. HAMPSON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 27

Feb 15

17

I HEREBY CERTIFY, That I attended deceased from Feb 13, 19 27, to Feb 15, 19 27,

that I last saw h.. alive on Feb 13, 19 27,

and that death occurred, on the date stated above, at 5 p m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(duration) .....yrs. .....mos. 2 ds.

CONTRIBUTORY (Secondary) Died suddenly following convulsion

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Nothing

(Signed) [illegible], M. D.

7/16, 19 27 (Address) 1319 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Edmondson Hill Cem Feb 17 19 27

20 UNDERTAKER — ADDRESS

U. Howard Evans 58 E. Fort

Be sure to print name, address and occupation very plainly. See instructions on back of certificates. EXACT Statement of OCCUPATION is very important.

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E-19073

E 19073

## CERTIFICATE OF DEATH

REGISTERED NO. 31

1-PLACE OF DEATH

City of BALTIMORE: (No. 2815 O'Donnell St St., 1-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Franciszek Zacek

(a) RESIDENCE NO. 2815 O'Donnell St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S. if of foreign birth 4 yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1904 - Jan 13

7 AGE: Years 23 Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Michal Zacek

11 BIRTHPLACE OF FATHER (City or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Mary Lubowicz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Mary Zacek

(Address) 2815 O'Donnell St

15 Filed 6 1927

C. HAMPSON JONES, M. D. Registrar

Per R.C.B.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Febr. 1, 1927, to February 14, 1927, that I last saw h alive on Febr. 9, 1927, and that death occurred, on the date stated above, at 4.40 p. m.

The CAUSE OF DEATH* was as follows:

Heart failure

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Phthysis pulmonum

(duration) yrs. 6 mos. ds.

18 Where was disease contracted: Unknown

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination.

(Signed) Jos. A. Rosenblatt, M. D.

2/15, 1927 (Address) 3018 O'Donnell St. Balto Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Cem

Date of Burial: Feb 17 1927

20 UNDERTAKER: Stephen Galkowski

ADDRESS: 1700 Remora Rd

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 19074

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

10-001

10 E 19074

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1537 Division St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stephonso Heam

(a) RESIDENCE NO. 1537 Division St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | col | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1894

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 33 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer) — 70

(c) Name of employer

9 BIRTHPLACE (city or town) Va.

(State or country)

PARENTS

10 NAME OF FATHER Jno. Heam

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Martha Heam

(Address) 1537 Division St

Filed 6 1927 C. HAMPSON JONES, M. D. Registrar

Per [illegible]

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) February 16 1927

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1927, to July 15, 1927, that I last saw him alive on July 10, 1927, and that death occurred, on the date stated above, at 5.30A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm E. Wyant, M. D.

2/16 1927 (Address) 1006 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Locust Hill Va Date of Burial Feb 16/27

20 UNDERTAKER Daniel Easton ADDRESS 516 Gay

IF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 19075 **HEALTH DEPARTMENT—CITY OF BALTIMORE** E 19075

## CERTIFICATE OF DEATH.

31

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 107 N Bond St. 6-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Stewart

(a) RESIDENCE NO. 107 N Bond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | Col | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Irene Stewart

6 DATE OF BIRTH (month, day, and year) Mr 25 1893

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 33 | 2 | 20 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Johnson Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Annie Ceplar

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Annie Stewart (Address) 107 N. Bond St

15 Filed 6 1927 19 C. HAMPSON JONES, M. D. Registrar Per ACH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 15 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 14 1927 to Feb 15 1927

that I last saw h alive on Feb 15 1927

and that death occurred, on the date stated above, at 11.15 A. m.

The CAUSE OF DEATH was as follows:

Acute Pneumonia Alcum

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Tuberculosis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Bernard Sachs, M. D.

19 (Address) 38 S Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westminster DATE OF BURIAL Feb 16 1927

20 UNDERTAKER C. Edw Poulson ADDRESS 5a ave

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 lks.

E 19076

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19076

## CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1424 Vincent St 15-21 WARD)

2-FULL NAME Catherine Brown Fuller Council

(a) RESIDENCE No. 1424 n. Vincent ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Council

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE: Years 56; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

027

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mazie Tracy

(Address) 1424 Vincent st.

15 Filed 1 6 1927, 19 C. HAMPSON JONES, M. D. Registrar

Rec'd D.H.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-14 1927

17

I HEREBY CERTIFY, That I attended deceased from 11-13-, 1926, to 2-14-, 1927.

that I last saw h er alive on 2-13-, 1927.

and that death occurred, on the date stated above, at 2.30 p. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary): Sciatica

(duration) yrs. 3 mos. ds.

over

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No. Date of -

Was there an autopsy? No.

What test confirmed diagnosis? -

(Signed) George C. Page, M. D.

, 19 (Address) 816 n. Mount St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: Feb 14 1927

20 UNDERTAKER: Wm. T. Easton

ADDRESS: 916 Paine

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19077

E 19077

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Cor Pitts & Barre St. 22-30 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Collins

(a) RESIDENCE NO. Cor Pitts & Barre St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of not married

6 DATE OF BIRTH (month, day, and year) Aug 13, 1880

| 7 AGE | Years | Months | Days | If LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 46 | 6 | 1 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance Collector

(b) General nature of industry, business, or establishment in which employed (or employer) 072

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Delaware

PARENTS

10 NAME OF FATHER James A Collins

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Delaware

12 MAIDEN NAME OF MOTHER Susan A Primrose

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Delaware

14 Informant Leonard A Collins

(Address) Delaware

15 Filed 6 1927 C. HAMPSON JONES, M. D. Registrar

Per

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/14 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Cardiac Hemorrhage

Arterial Sclerosis

Duration (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) (Coroner) M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Clayton Del.

19 PLACE OF BURIAL, CREMATION OR REMOVAL Clayton Del. Date of Burial Feb 16 1927

20 UNDERTAKER George J Smith ADDRESS Hollins

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 19078

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19073

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hospital St. 16-22 Ward) 74-001

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Andreos

(a) RESIDENCE NO. Unknown St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred OK yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | Unknown |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1861

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 66 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer

9 BIRTHPLACE (city or town) Feb. 15 1927

(State or country) Unknown

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant N. W. Dill Co

(Address) Penna Ave

Feb 16 1927 C. HAMPSON JONES, M. D.

Per Registrar

FOR MORGUE.

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 15 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 1 mos. ds.

(Signed) C. C. Hamman, M. D.

(Coroner)

(Address) 786 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

JOHNS HOPKINS HOSPITAL

20 UNDERTAKER — ADDRESS

Commissioner Health.

FEB 16 1927

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19079

E 19079

## CERTIFICATE OF DEATH.

100-08

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 92 W. Cullob St. St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gertrude Nicholas

(a) RESIDENCE NO. 92 W. Cullob St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 Color or Race: colored | 5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 18, 1926.

7 AGE — Years: — Months: 1 — Days: 24 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) Feb. 15, 1927
(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Nicholas

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER ? Nicholas

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Mrs. Gertrude Nicholas
(Address) 92 W. Cullob St.

C. HAMPSON JONES, M. D.
Registrar

6 1927 Per. 1040

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 11 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) 2 yrs. mos. ds.

(Signed) J. J. Hennessy, M. D.
(Coroner)

192 (Address) 290 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — Date of Burial 19

20 UNDERTAKER: Commissioner Health. — ADDRESS

FEB 16 1927

very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19080 | CERTIFICATE OF DEATH. | 129 E 19080

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St. 6-9 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Jackson

(a) RESIDENCE NO. 1727 Orleans St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | Negro | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1852

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 75 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Joe Jackson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary ——

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant

(Address) Ricardo

Filed FEB 6 1927 C. HAMPSON JONES, M. D. Registrar

Ref 1050 DRR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 12 1927

17

I HEREBY CERTIFY, That I attended deceased from February 10, 1927, to February 12, 1927,

that I last saw him alive on February 12, 1927,

and that death occurred, on the date stated above, at 9.50 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Arterial Sclerosis

Chronic Myocarditis & Insufficiency

(duration) ? yrs. mos. ds.

CONTRIBUTORY Myocardial failure

(Secondary)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? general & laboratory

(Signed) R Hooper Smith M. D.

Feb 13 1927 (Address) [redacted]

BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial FEB 14 1927

JOHNS HOPKINS HOSPITAL

20 UNDERTAKER — ADDRESS

Bureau of Vital Statistics

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19081

## CERTIFICATE OF DEATH.

129

E 19081

REGISTERED NO. _____

1-PLACE OF DEATH

City of BALTIMORE: (No. 604 Redwood St. 4-25 Ward

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Anderson

(a) RESIDENCE NO. 604 W Redwood St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | Not Known |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not Known

6 DATE OF BIRTH (month, day, and year) Not Known

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| About 60 | | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Not Known

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Md

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Md

14 Informant _____

(Address)

15 Filed _____, 19 _____

Per _____ Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/11 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

Chronic Interstitial Nephritis

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) _____

(duration) _____ yrs. _____ mos. _____ ds.

(Signed) Chas. Hampson Jones, M. D.

(Coroner)

, 19 27 (Address) 825 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death _____ yrs., _____ mos., _____ ds. In the state _____ yrs., _____ mos., _____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL Date of Burial _____ 19

20 UNDERTAKER _____ ADDRESS _____

Commissioner Health.

FEB 16 1927

Per A. F. Russell

FEB 16 1927

THE MORGUE. 1054

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19082

## CERTIFICATE OF DEATH.

167-001

E 19082

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 506 W Fayette St., 4-25 Ward)

2-FULL NAME H. Fisher

(a) RESIDENCE NO. 506 W Fayette St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | not known |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of not known

6 DATE OF BIRTH (month, day, and year) ?

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| About 60 | | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work not known

(b) General nature of industry, business, or establishment in which employed (or employer) not known

(c) Name of employer

9 BIRTHPLACE (city or town) not known

(State or country)

PARENTS

10 NAME OF FATHER not known

11 BIRTHPLACE OF FATHER (city or town) not known

(State or country)

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) not known

(State or country)

14 Informant .....

(Address)

15 Filed ....., 19 ..... Reg.

C. HAMPSON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/24 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Asphyxiating gas

Suicidal

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Samuel A. Levin M. D.

(Coroner)

, 19 27 (Address) 330 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Johns Hopkins Hospital Date of Burial 19

20 UNDERTAKER ADDRESS

Commissioner Health

FEB 16 1927

Reg. No.

1927

MORGUE

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 19083

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19083

## CERTIFICATE OF DEATH.

10-E 19083

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1648 Mulliken Ave ST. 19-27 WARD)

2-FULL NAME Bernard Johnson

(a) RESIDENCE NO. 1648 Mulliken Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 9 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colour | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) July 13 1922

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 4 yr | 7 | 2 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer none

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Perry Johnson

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Lilly Jackson

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Perry Johnson
(Address) 1648 Mulliken Ave

15 Filed FEB 6 1927 19 C. HAMPSON JONES, M. D. Registrar
By

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 15 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 14, 1927, to Feb 15, 1927.

that I last saw h alive on Feb 15, 1927.

and that death occurred, on the date stated above, at 12 PM m.

The CAUSE OF DEATH* was as follows:

Pharyngeal Diphtheria

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) not known

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Balto City Health Dept

(Signed) R L Caslow M. D.

, 19 (Address) 1514 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery DATE OF BURIAL Feb 16 1927

20 UNDERTAKER Milton Davis ADDRESS E Eden St

THIS IS very important. See instructions on back of certificate.

Spec. -7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19084

## CERTIFICATE OF DEATH

E 19084

1-PLACE OF DEATH — REGISTERED NO. 12-51

City of BALTIMORE: (No. 2915 Huntington Ave St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lina Alston McDonald.

(a) RESIDENCE NO. 2915 Huntington Ave. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred about 5 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 14th 1859

7 AGE — Years: 69 Months: 8 Days: 9 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer): Sharp & Dome 009

(c) Name of employer

9 BIRTHPLACE (city or town): Columbia S. C.

(State or country)

PARENTS

10 NAME OF FATHER: D. P. McDonald

11 BIRTHPLACE OF FATHER (City or town): S. C.

(State or country)

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): Unknown

(State or country)

14 Informant: Mrs Mary Stillens

(Address) 2115 Eat St.

6 1927 C. HAMPSON JONES, M. D. Registrar

Per Dr Frank.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feby 13 1927

17 I HEREBY CERTIFY, That I attended deceased from July 13" 1927 to July 13 1927

that I last saw h[illegible] alive on 2/13 1927

and that death occurred, on the date stated above, at 12 15 m.

The CAUSE OF DEATH* was as follows:

Pleuro Pneumonia

(Contusion Chest)

(duration) yrs. 1 mos 6 ds.

CONTRIBUTORY (Secondary) X X

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. Hawkins M. D.

, 19 (Address) 1340 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Columbia S.C. Date of Burial Feb. 17 1927

20 UNDERTAKER: Margaret J. Flynn ADDRESS 1422 Light St.

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 19085

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19085

## CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH U. S. Marine Hospital #1

CITY OF BALTIMORE: (No. Baltimore Sub ST. 3-5 WARD)

2-FULL NAME George L. Lomax

(a) RESIDENCE NO. 728 East Pratt ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male. | White | Single. |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar. 8. 1868

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 58 | 11 | 7 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) Mate

(c) Name of employer Schooner Robert Maryland

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Richard B Lomax.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Eliza Cox

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Self

(Address)

Filed FEB 16 1927 C. HAMPSON JONES, M. D., Registrar

Per R.S.H.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 15 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1927, to Feb 15, 1927,

that I last saw him alive on Feb 15, 1927,

and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic

Unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Symptoms & Findings

(Signed) J. C. Grauss, M. D.

, 19 (Address) U.S. Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Cathedral Cemetery

DATE OF BURIAL Feb 17 1927

20 UNDERTAKER C. J. Fanning & Son

ADDRESS 1116 Park Ave

Spec.—1-10-21—M&T—1500 Bks.

ADAMS ✓

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19086

E 19086

## CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 304 E Fortune St. 24-33 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Juanita adams

(a) RESIDENCE NO. 304 E Fortune ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph E adams

6 DATE OF BIRTH (month, day, and year): Aug 21 1851

7 AGE: Years 72 Months 6 Days 24 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not known

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not known

14 Informant (Address): Mrs. Pye 304 E Fortune St.

15 Filed 6 1927 C. HAMPSON JONES, M. D. Registrar Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 14 1927

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1926, to Feb 14, 1927, that I last saw h alive on Feb 14, 1927, and that death occurred, on the date stated above, at 7 30 m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis with cardio vascular disease

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary): Cerebral hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm E Hagner, M. D.

Feb 16, 1927 (Address) 1319 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: 2/17/1927

20 UNDERTAKER: E. C. Fleming Inc — ADDRESS: 1201 Baltimore

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

Denton ✓

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19087 31 E 19087

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2019 St. Paul Street ST. 12-19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ephriam Maxfield Denton

(a) RESIDENCE NO. 2019 St. Paul Street ST., 12 WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 52 yrs. 2 mos. 9 ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Anna D. Denton

6 DATE OF BIRTH (month, day, and year) Dec-6-1874

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs. or ....min. |
|---|---|---|---|---|
| | 52 | 2 | 9 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer) Chemicals

(c) Name of employer Comercial Chemical Co.

9 BIRTHPLACE (city or town) Phoenix.
(State or country) New York

PARENTS

10 NAME OF FATHER Albert L. Denton

11 BIRTHPLACE OF FATHER (city or town) Phoenix
(State or country) New York

12 MAIDEN NAME OF MOTHER Anna Maxfield

13 BIRTHPLACE OF MOTHER (city or town) Phoenix
(State or country) New York

14 Informant Mrs. Anna D. Denton (wife)
(Address) 2019 St. Paul Street

15 6 1927 C. HAMPSON JONES, M. D. Registrar
Per Apr 15

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb-15-1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 28, 1927, to Feb. 15, 1927, that I last saw him alive on Feb. 15, 1927, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

acute exacerbation lasting

(duration) yrs. mos 23 ds.

CONTRIBUTORY (Secondary) Chronic phthisis (duration) 5 yrs. mos. ds.

18 Where was disease contracted, if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Auscultation.

(Signed) E. T. Bonchelle, M. D.

2-16 1927 (Address) 2104 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Phoenix, New York

DATE OF BURIAL: Feb-18-27 19

20 UNDERTAKER: STEWART & MOWEN COMPANY (Successor)

ADDRESS: 109 W. NORTH AVE.

Spec.—1-12-23—M&T—500 Bks.

E 19088

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19088

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Home for Incurables

CITY OF BALTIMORE: (No. Cedar Ave & 40th St. 13-52 Ward)

REGISTERED NO. 100

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Blanche Ellsler

(a) RESIDENCE NO. Home for Incurables ST., WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 8 mos. 2 ds. How long in U. S., if of foreign birth? 58 yrs. 8 mos. 2 ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none.

6 DATE OF BIRTH (month, day, and year) June 12 1868

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 58 yrs | 8 | 2 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kiod of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Henry Ellsler

11 BIRTHPLACE OF FATHER (city or town) Philadelphia (State or country) Penna

12 MAIDEN NAME OF MOTHER Martha Snyder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Maryland

14 Informant Mr Geo Ellsler (bro)

(Address) 99 Westminster N. Y. City

Filed FEB 16 1927 O. HAMPSON JONES, M. D. Registrar

Pat. ORS

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Septembr 19 27. to Feby 14 1927.

that I last saw her alive on Feby 14 1927.

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary oedema

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secoodary) Broncho pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operatioo precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Wm B Mayo, M. D.

2/ , 1927 (Address) Baltimore Md

*State the Disease Causing Death, or in deaths from Violeot Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery

DATE OF BURIAL Feb 17 1927.

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

E 19089 HEALTH DEPARTMENT—CITY OF BALTIMORE E 19089

# CERTIFICATE OF DEATH.

182

1-PLACE OF DEATH
City of BALTIMORE: (No. Harbor Foot of Clinton St 11-No St. Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob C. Anderson

(Residence in Baltimore: No. 640 W. Franklin St.; yrs. Unknown mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

| 3-SEX. | 4-COLOR OR RACE. | 5-Single, Married, Widowed, or Divorced. (Write the word.) |
|---|---|---|
| Male | White | Single |

6-DATE OF BIRTH. ..... 1888 (Month) (Day) (Year)

| 7-AGE. | If LESS than 1 day, |
|---|---|
| 39 yrs. mos. ds. | hrs. or min.* |

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of Industry, business, or establishment in which employed (or employer) Sailor SS

9-BIRTHPLACE, (State or Country). Denmark

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER, (State or Country). Unknown

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Records

(Address).....

15- FEB 6 1927 C. HAMPSON JONES, M. D. 192 Per ..... Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Feb 15 ....., 192 7 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acc Drowning Ms Auto.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Asphyxia

(Duration) ..... yrs. ..... mos. ..... ds.

Signed Feb 14 27 Geo. Clinton Bayless M. D. (Coroner) 192.... (Address) 1432 E Biddle

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.
Trinity Cem. Feb 18 1927

20-UNDERTAKER. John M Wilken ADDRESS 1803 Bank
John Wilken 2008 Edmondson

Spec.—1-12-23—M&T—500 Bks.

E 19090

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 19090

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 817 N Monroe ST. 20-27 WARD)

2-FULL NAME Rose J Blair

(a) RESIDENCE NO. 902 Pierce Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jas J Blair

6 DATE OF BIRTH (month, day, and year): July 30 1858

7 AGE: Years 68 Months 6 Days 15 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: John Dorn

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Neal

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Jas J Blair

(Address) 1401 Pierce Ave

15 Filed 6 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2-15-1927

17 I HEREBY CERTIFY, That I attended deceased from 12-1, 1926, to 2-16, 1927, that I last saw her alive on 2-15, 1927, and that death occurred, on the date stated above, at 7.40 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Bronchitis (acute)

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? At Home.

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Physic. exam.

(Signed) W J Bryant, M. D.

2/16, 1927 (Address) 1928 N Luther Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem

DATE OF BURIAL: 2/17 1927

UNDERTAKER: George W Talley

ADDRESS: Fulton & Fayette

Spec.—1-12-23—M&T—500 Bks.

# E 19091 HEALTH DEPARTMENT—CITY OF BALTIMORE. 29E 19091

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U. S. Marine Hospital 16 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Mitchell

(a) RESIDENCE NO. 911 West Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. 6 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) August 14, 1879

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 47 | 6 | 1 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman 086

(b) General nature of industry, business, or establishment in which employed (or employer) Coal aboard ship

(c) Name of employer Ship "Corinthia"

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Mitchell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER — Rowlton

13 BIRTHPLACE OF MOTHER (city or town) Annapolis (State or country) Maryland

14 Informant Hospital records

(Address)

15 Filed 6 1927 C. HAMPSON JONES, M. D. Registrar

By —

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 15 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 7, 1927, to Feb 15, 1927, that I last saw h[illegible] alive on Feb 15, 1927, and that death occurred, on the date stated above, at 1 35 A. m.

THE CAUSE OF DEATH* was as follows:

Valvular Heart Disease (Mitral incompetency) with decompensation

(duration) yrs. mos 10 (?) ds.

CONTRIBUTORY (Secondary) Nephritis. chronic

(duration) yrs. mos. 10 (?) ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings and Laboratory tests

(Signed) W W Beaton Asst Surgeon U.S.P.H.S., M. D.

, 19 (Address) U.S Marine Hospital Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mang's Hampden

DATE OF BURIAL Feb 17 1927

20 UNDERTAKER E. L. Roy Steffen

ADDRESS 1217 North Ave

C[illegible]—1-12-23—M&T—100 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19092 E 19092

## CERTIFICATE OF DEATH.

REGISTERED NO. 12-507

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2741 N Charles ST. 12 WARD)

2-FULL NAME Charles Haskins

(a) RESIDENCE No. 2741 N. Charles ST., 12 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): [illegible]

| 7 AGE | Years | Months | Days | If LESS than 1 day, .. hrs. or .. min. |
|---|---|---|---|---|
| | 54 | | | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer): 021
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

10 NAME OF FATHER: [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): [illegible]

14 Informant: Dr. Gascoyne
(Address) 2741 N. Charles

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar
Per [illegible]

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/15/27 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Arteriosclerosis.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)

2/16, 192 (Address) 2532 Rolland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., .. mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Laurel Cem | Feb 7 1927 |
| 20 UNDERTAKER | ADDRESS |
| E. L. Roy Stephens | 1257 North ave |

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19093

## CERTIFICATE OF DEATH.

159-007

E 19093

1-PLACE OF DEATH

City of BALTIMORE: (No. 3650 Cedar Av St. 13-57 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Wilson

(a) RESIDENCE NO. 3650 Cedar Av St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | — |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 15. 1927

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | — | — | 1 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Chas H. Wilson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto Co.

12 MAIDEN NAME OF MOTHER Bessie M. Varner

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto Md

14 Informant Chas. H. Wilson
(Address) 3650 Cedar Av

15 Filed ..... 19 ..... Registrar

very important. See instructions on back of certificates.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 16. 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 15 1927, to Feb. 16, 1927, that I last saw h~~er~~ alive on Feb 15 1927, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Foramen Ovale not Closed

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted
If not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) H. L. Fair, M. D.
, 19 (Address) 2704 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Pine Grove Cem — Date of Burial Feb 17 1927

20 UNDERTAKER — E. LeRoy Stiffler — ADDRESS 125 E North Ave

1927 C. HAMPSON JONES, M. D.
Registrar

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19094 E 19094

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Joseph's Hospital. REGISTERED NO. 101

CITY OF BALTIMORE: (No. ) ST. 16-20 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard Engler.

(a) RESIDENCE NO. 622 Edgewood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | white | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Susan A England

6 DATE OF BIRTH (month, day, and year) July 24, 1875

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 51 | 6 | 20 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Supt of Insurance 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Home Friendly

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Asa Englar

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Anderson

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 Informant Susan A Englar

(Address) 622 Edgewood Et

15 Filed FEB 16 1927, 19 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/14/27 19 27.

17 I HEREBY CERTIFY, That I attended deceased from Jan 4, 1927, to Feb 14, 1927, that I last saw him alive on Feb 14, 1927, and that death occurred, on the date stated above, at 9 55 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia —

Uncomplicated

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary) Heart failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Clement B. Mowar, M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem

DATE OF BURIAL Feb 18 1927

UNDERTAKER W. H. Cook

ADDRESS 502 E North Ave

Spec.—1-12-23—M&T—500 Blks.

E 19095

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 19095

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No.) ST. 12-50 (WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Courtney Kinsey

(a) RESIDENCE No. 2209 Barclay ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 ~~Single~~, Married, ~~Widowed, or Divorced, (write the word)~~ |
|---|---|---|
| Female | White | Married |

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of Everett Kinsey

6 DATE OF BIRTH (month, day, and year) July 31, 1902

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 24 | 6 | 14 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Charles D Gilmore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Rosa B Pearce

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 Filed FEB 6 1927, 19 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 15 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 12, 1927, to Feb 15, 1927, that I last saw h~~er~~ alive on Feb 15, 1927, and that death occurred, on the date stated above, at 9.45 m.

The CAUSE OF DEATH* was as follows:

Goiter (toxic)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis Sec.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Feb 14 1927

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Henry A. Peterson, M. D.

, 19 (Address) Johns Hopkins Hospital Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem DATE OF BURIAL Feb 18 1927

20 UNDERTAKER Jeffrey Cook ADDRESS 502 E North Ave

Spec.-7-17-26—A Co.—200 Bks.

Dr Roberts Preston & St Paul Sts

HEALTH DEPARTMENT—CITY OF BALTIMORE No 6689.

4307 Richmond Ave

E 19096

CERTIFICATE OF DEATH

E 19096

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 3718 Yosemite Ave St. 15-62 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline G Folsom

(a) RESIDENCE NO. 3718 Yosemite St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James S Folsom

6 DATE OF BIRTH (month, day, and year): July 5, 1852

7 AGE: Years 74 Months 7 Days 9 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Mass

PARENTS

10 NAME OF FATHER: Thomas Atkins

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Mass

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Mass

14 Informant: Emma G Folsom

(Address): 3718 Yosemite Ave

17 1927 C. HAMPSON JONES, M. D. Registrar

Per ORB

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 8, 1926, to Feb. 11, 1927, that I last saw h[illegible] alive on Feb 11, 1927, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Sarcoma right lung

about 6 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation 2 hrs.

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? None Date of

Was there an autopsy? No

What test confirmed diagnosis? X-Ray

(Signed) J. H. Roberts M. D.

. 19 (Address) 1300 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem

Date of Burial: Feb 17 1927

20 UNDERTAKER: J. Cook

ADDRESS: 502 E Lexington

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

1917 5 Homewood Terrace

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19097

## CERTIFICATE OF DEATH

90 E-19097

1-PLACE OF DEATH

REGISTERED NO. R27-53

City of BALTIMORE: (No. 216 Edgevale St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances E. Edwards

(a) RESIDENCE NO. 216 Edgevale Road St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 91 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced (or) WIFE of: John R. Edwards

6 DATE OF BIRTH (month, day, and year): Jan-24-1836

7 AGE: Years 91 Months Days 20 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER: Francis D. Dolphin

11 BIRTHPLACE OF FATHER (City or town)

(State or country) France

12 MAIDEN NAME OF MOTHER: Veronica Dolphin

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto Md

14 Informant: Mae H. Kraft

(Address) 216 Edgevale Road

15 Filed 6 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 14th 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 1 1927 to Feb 13 1927

that I last saw h[illegible] alive on Feb 13 1927

and that death occurred, on the date stated above, at 11 15 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Walter Stonner, M. D.

2/16/27 (Address) 3401 Garrison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — Date of Burial 2/17 1927

20 UNDERTAKER: William Cook — ADDRESS 502 E North Ave

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19098

167-001

## CERTIFICATE OF DEATH.

E 19098

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1514 N. Gay St St. 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nellie M. Ames

(a) RESIDENCE NO. 1514 N. Gay St St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | white | divorced |

5a If married, widowed, ~~or divorced~~ ~~HUSBAND~~ of (or) WIFE of Howard Ames

6 DATE OF BIRTH (month, day, and year) Feb 18/1899

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 27 | 11 | 26 28 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar Maker 017

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Franklinville, Md

PARENTS

10 NAME OF FATHER Frank Ray

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Harford Co., Md

12 MAIDEN NAME OF MOTHER Lillie Gordon

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto., Md.

14 Informant Lillie Ray (mother)

(Address) Franklinville Md.

15 Filed 1-7 1927 16 HAMPSON JONES, M. D.

Registrar

Per RK

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 10 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Illuminating Gas Asphyxiation

Suicide

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Collins M. D.

(Coroner)

19 2/10/27 (Address) 508 E. Northeve

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ..... mos., ..... ds. In the State ..... yrs., ..... mos., ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery Date of Burial Feb 18 1927

20 UNDERTAKER Robt J Turner & Co ADDRESS N. Broadway

very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002

E 19099

## CERTIFICATE OF DEATH

E 19099

REGISTERED NO.

1. PLACE OF DEATH

City of BALTIMORE: (No. 1757 E Preston St., 7-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Appel

(a) RESIDENCE NO. 1757 E Preston St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: White

5 ~~Single~~, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~: Mary Ellen Appel

6 DATE OF BIRTH (month, day, and year): Jany 16 1856

7 AGE: Years 71 Months Days 29 30

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Inspector

(b) General nature of industry, business, or establishment in which employed (or employer): Can Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Martin Appel

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Germany

14 Informant (Address): Mary Ellen Appel 1757 E Preston st

Filed FEB 17 1927 J. HAMPTON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 15 1927

17 I HEREBY CERTIFY, That I attended deceased from Jany 10, 1926 to Feb 15th 1927

that I last saw h~~im~~er alive on Feby 15th 1927

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Interna Sclerosis

Cannot say Dysentery

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Coma

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

. 19 (Address) 1501 E Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery

Date of Burial: Feb 18 1927

20 UNDERTAKER: Roll & Turner

ADDRESS: 1112 N. Broadway

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19100

## CERTIFICATE OF DEATH.

38

E 19100

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1412 Mulliken ST. 5-8 WARD)

2-FULL NAME Maryzon Brown

(a) RESIDENCE NO. 1412 Mulliken ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Jan. 22, 1926

7 AGE: Years 1 1/12 Months Days 23 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto, Md.

PARENTS

10 NAME OF FATHER: Emmett Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Jacksonville Fla.

12 MAIDEN NAME OF MOTHER: Mary Bazil

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Dorchester Co. Md.

14 Informant (Address): Emmett Brown 1412 Mulliken

15 Filed ◆ . . 19 . HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 15 1927

17 I HEREBY CERTIFY, That I attended deceased from 2/15 . 1927 . to 2/15 . 1927.

that I last saw her alive on 2/15 . 1927.

and that death occurred, on the date stated above, at 8:30 P.m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Luetic infection

(duration) yrs. mos. ds.

Congenital

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Signs

(Signed) Jos. H. Blake M.D.

(Address) 1432 Jefferson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury cemetery

DATE OF BURIAL: Feb 18 1927

20 UNDERTAKER: Edward Bryan

ADDRESS 1691 orleans St

Spec.—1-10-21—M&T—1500 Bks.

E 19101

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

159 E 19101

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 904 S. Decker Ave (St.) 1 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam Hoerner

(a) RESIDENCE No. 904 S. Decker Ave (St.) WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: None

6 DATE OF BIRTH (month, day, and year): Feb. 15 1927.

7 AGE: Years — Months — Days 1 dy

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ✓ none

(b) General nature of industry, business, or establishment in which employed (or employer): ✓ none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Ernest Hoerner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Margaret Dears

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore, Md

14 Informant (Address): Ernest Hoerner (Father) 904 S. Decker ave

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 16 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 15. 1927. to Feb 15. 1927.

that I last saw h[illegible] alive on Feb 15. 1927.

and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

non closure of foramen ovale [illegible] cerebral Syncope

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): asphyxia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible] M. D.

(Address) 1614 S. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Schwarzes Cem. DATE OF BURIAL: Feb 17 1927

20 UNDERTAKER: Louis Heemann ADDRESS: 32 S Broadway

Spec.—12-9-25—A Co.—200 Bks.

Hendry

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19102

CERTIFICATE OF DEATH.

101-001

E 19102

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1608 W Franklin St., (Ward) 14-27

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Viola Hendry

(a) RESIDENCE NO 1608 W Franklin St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5y yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 21 — 1925

7 AGE: Years 1 Months 6 Days 25 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Unemployed

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Cornel Hendy

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Clinton S. C.

12 MAIDEN NAME OF MOTHER Annie Wagley

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Newville S C

14 Informant Cornel Hendy

(Address) 1608 W Franklin St

15 Filed 1927 G. HAMPSON JONES, M. D.

Registrar

Per

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 Jan-16

17 I HEREBY CERTIFY, That I attended deceased from Jan 16, 19 27, to Jan 16, 19 27, that I last saw h alive on Jan 16, 19 27, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Bilateral

(duration) yrs. mos. 3 ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted? Not Place of

If not at place of death? Unknown

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Sx

(Signed) W J Sloan M. D.

, 19 (Address) 1621 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Lebanon Cemetery — Date of Burial: Feb 17, 1927

20 UNDERTAKER: Katie R. Williams — ADDRESS 324 N. Schroeder St

Very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19103

74-001

## CERTIFICATE OF DEATH

E 19103

1-PLACE OF DEATH

City of BALTIMORE: (No.) 2502 Elmora ave St., 15-61 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carlile P Woodall

(a) RESIDENCE NO. 2502 Elmora ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sue B. Woodall

6 DATE OF BIRTH (month, day, and year): Nov 5 1873

7 AGE: Years 53 Months 3 Days 9

IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Shipper

(b) General nature of industry, business, or establishment in which employed (or employer): Chandler

(c) Name of employer: Self

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER James Woodall

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Rothe

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant: Sue B. Woodall

(Address) 2502 Elmora

15 Filed FEB 17 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 Feb 14/1927.

17 I HEREBY CERTIFY, That I attended deceased from Dec 10, 1926, to Feb 14, 1927.

that I last saw him alive on Feb 14, 1927.

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage and Paralysis — Right side (Paralysis Salivation)

(duration) yrs. mos. 5/ ds.

CONTRIBUTORY (Secondary) Paralysis Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) W. S. Hublett, M. D.

19 (Address) 2220 Garrison Ave

Feb 17/27

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet

Date of Burial: Feby 1 1927

20 UNDERTAKER: H. J. Tarbert & Son

ADDRESS: North Ave

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

100-001

E 19104

REGISTERED NO. E 19104

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes. Hospital 6-63 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Meiser

(a) RESIDENCE NO. 5004 Liberty Heights St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. 11 mos. 17 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, (Married,) Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances M. Meiser

6 DATE OF BIRTH (month, day, and year) February 28-1886

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..hrs. or ..min.. |
|---|---|---|---|---|
| XX | 40 | 11 | 17 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Grocery

(c) Name of employer J. H. Crook Co

9 BIRTHPLACE (city or town) Balto. Md

(State or country)

PARENTS

10 NAME OF FATHER Jacob Meiser.

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Smith

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany.

14 Informant Fred Raymenig

(Address) 3808 Packard Ave City

Filed FEB 17 1927 Registrar H. HAMILTON JONES, M. D.

Per L K

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 2-15

17 I HEREBY CERTIFY, That I attended deceased from 2-15, 1927, to 2-15, 1927.

that I last saw him alive on 2-15, 1927.

and that death occurred, on the data stated above, at 5-30 m.

The CAUSE OF DEATH* was as follows:

BRONCHO PNEUMONIA

(duration) yrs. mos. 10 ds.

CONTRIBUTORY MYOCARDIAL INSUFFICIENCY

(Secondary)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? PHYSICAL FINDINGS

(Signed) W. L. McBride M. D.

2/15. 1927 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

Date of Burial Feb 18 1927

20 UNDERTAKER J. J. Tickner & Sons

ADDRESS North Ave

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

19990 E 19105

## CERTIFICATE OF DEATH.

X 44 E 19105

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ) ST. 7-9 WARD )

2-FULL NAME Daniel Lucas -

(a) RESIDENCE NO. Suffolk Va - ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of #

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min |
|---|---|---|---|---|
| | 29 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N.C.

PARENTS

10 NAME OF FATHER Archie Lucas

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Adeline Andrey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant Records - (Address) JOHNS HOPKINS HOSPITAL

15 Filed FEB 7 1927 19 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 15- 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 4 , 1927 , to Feb 15- , 1927 , that I last saw him alive on Feb 15- , 1927 and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach, E metastases to mesenteric glands.

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs mos ds.

18 Where was disease contracted if not at place of death? Suffolk Va

Did an operation precede death? Yes Date of Feb 7, 1927.

Was there an autopsy? No

What test confirmed diagnosis? Exploratory Operation

(Signed) E. E. Jones, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fayetteville N C

UNDERTAKER Robert Brooks & Son

DATE OF BURIAL 2/17 1927

ADDRESS Calhoun Hollins St

Spec.—1-12-23—M&T—500 Bks.

Briscoe

E 19106

# HEALTH DEPARTMENT--CITY OF BALTIMORE

90 E 19106

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2126 McCulloh St. 13-54 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Flora L Briscoe

(a) RESIDENCE NO. 2126 N. McCulloh ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced (or) WIFE of: Alonzo L. Briscoe

6 DATE OF BIRTH (month, day, and year): Mar. 18, 1895

7 AGE: Years: 31; Months: 10; Days: 27; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Hairdresser

(b) General nature of industry, business, or establishment in which employed (or employer): Beauty Shop

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Jesse Barkley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Frances DeShields

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Alonzo L. Briscoe Husband

(Address) 2126 McCulloh St

15 Filed 1-7 1927 19 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/5 19 27

17 I HEREBY CERTIFY, That I attended deceased from 12/13 19 27 to 1/5 19 27,

that I last saw h alive on 1/5 19 27,

and that death occurred, on the date stated above, at 2 A m

The CAUSE OF DEATH* was as follows:

Influenza

Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Sup Welty, M. D.

1/7 19 27 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery

UNDERTAKER: Jno. M. Johnson

DATE OF BURIAL: Feb 17 1927

ADDRESS 1234 Eutaw St

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19107

## CERTIFICATE OF DEATH

90 E 19107

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 411 Robert St. St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Heath

(a) RESIDENCE NO. 411 Robert St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed or divorced HUSBAND of (or) WIFE of: John Heath

6 DATE OF BIRTH (month, day, and year): Dec 1867

7 AGE: Years 59 Months 2 Days 1

IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Accomac Co Va

PARENTS

10 NAME OF FATHER George Mapson

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Margt West

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Virginia

14 Informant: Margt E Coste

(Address) 411 Robert St

15 Filed: C. HAMPSON JONES, M. D. Registrar

By RJC

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 16 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 6, 1927, to Feb 16, 1927,

that I last saw h.. alive on Feb 16, 1927,

and that death occurred, on the date stated above, at 12.05 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. William Frey M. D.

2/16, 1927 (Address) 9.28 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Accomac Co Parsons Bay Va

Date of Burial: Feb 18th 1927

20 UNDERTAKER: Haines & Bright

ADDRESS: 364 Main

Very important. See instructions on back of certificates.

FEB 17 1927

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19108
1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

16 E 19108
REGISTERED NO.

City of BALTIMORE: (No. Sinai Hospital St., 27-56 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Baby (Boy) Hunwitz

(a) RESIDENCE NO. 472 Pimlico Rd. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | White | |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 13/27

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| ✓ | | | 3 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work do

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto md.

PARENTS

10 NAME OF FATHER Sidney Hunwitz

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia.

12 MAIDEN NAME OF MOTHER Rebecca Hunwitz

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Sidney Hunwitz

(Address) 472 Pimlico Rd

15 Filed 1 7 1927 C. HAMPSON JONES, M. D. Registrar

Rec'r

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

2-16-27

17

I HEREBY CERTIFY, That I attended deceased from 2-13, 1927, to 2-16, 1927, that I last saw h.m alive on 2-16, 1927 and that death occurred, on the date stated above, at 6 20 a. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage of New Born

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? clinically

(Signed) Harry Weinstein, M. D.

2/17, 1927 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt Carmel Date of Burial Feb 17 1927

20 UNDERTAKER J. Levinson Bro ADDRESS 1127 E Balto St.

Key Important. See Instructions on Back of Certificate.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19109

## CERTIFICATE OF DEATH

1001 ✓

100 E 19109

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 233 E Hoffman St. 24-34 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles V. Young

(a) RESIDENCE NO. 233 E Hoffman St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Aug 5 1926

7 AGE: Years — Months 6 Days 11 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country): Md

PARENTS

10 NAME OF FATHER Charles V. Young

11 BIRTHPLACE OF FATHER (City or town): Balto

(State or country)

12 MAIDEN NAME OF MOTHER Honora V. Brown

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country)

14 Informant Charles V. Young

(Address) 233 E Hoffman

Filed 1927 G. HAMPSON JONES, M. D. Registrar

By R. J.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 16 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1927, to Feb 16, 1927, that I last saw h[illegible] alive on Feb 16, 1927, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

Primary

(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted —

If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. R. Campbell M. D.

1927 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem.

Date of Burial: Feb. 18 1927

20 UNDERTAKER: Margaret A. Flynn

ADDRESS: 1422 Light

Feb 17 1927

very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

153 ✓

E 19110 × E 19110

## CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. 4-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Mc Quay

(a) RESIDENCE NO. Sykesville. Md St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 16 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 10 1852

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 74 | 5 | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland.

PARENTS

10 NAME OF FATHER James Mc Quay

11 BIRTHPLACE OF FATHER (City or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER Sarah Gordon

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant Raymond McQuay.

(Address) R.F.D. Sykesville, Md.

15 Filed FEB 17 1927 19 Registrar C. HAMPTON JONES, M. D.

Ref.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 16th 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Jan. 30th 1927, to Feb. 16th 1927,

that I last saw h~~im~~ alive on Feb. 16th 1927,

and that death occurred, on the date stated above, at 8:45 P. m.

The CAUSE OF DEATH* was as follows:

Terminal Hypostatic pneumonia

Cardiac failure

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Cellulitis of whole right upper extremity

(duration) yrs. mos 14 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of Jan 30th 1927

Was there an autopsy? No

What test confirmed diagnosis? Clinical diagnosis

(Signed) Jacob Hjensen M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Carroll Co., Md. Ebenezer Cemetery. Date of Burial Feb. 20 1927

20 UNDERTAKER C. M. Waltz. ADDRESS Hunfield. Md.

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19111

## CERTIFICATE OF DEATH.

91-202 E 19111

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1109 Brentwood Ave ST., 10-15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Gill Hanly

(a) RESIDENCE NO. 1109 Brentwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thos. Hanly

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 95; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: James Gill

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Cath. Burns

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Miss Catherine McNeal

(Address): 1109 Brentwood Ave

15 Filed FEB 17 1927 C. HAMPSON JONES, M. D. Registrar

per R.K.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 17 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan 15, 1927, to Feb 17, 1927.

that I last saw h alive on Feb 12, 1927

and that death occurred, on the date stated above, at 8 am m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

General

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ??

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Hudson M. D.

2 17 1927 (Address) 7002 Chancery

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral

DATE OF BURIAL: Feb 19 1927

UNDERTAKER: Rita Wiedefeld

ADDRESS: 914 Fremont Ave

Fold is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19112

## CERTIFICATE OF DEATH.

90 E 19112

1-PLACE OF DEATH

City of BALTIMORE: (No. 2015 Oak St. 12-70 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Perry Collyer

(a) Residence No. 2015 Oak St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or ~~Divorced~~, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1847

7-AGE 80 yrs. mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) — 040

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country),

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country)

14- (Informant) Son Robert Emerson

(Address) 425 East 23 St

15- Filed OCT 7 1927 C. HAMPTON JONES, M. D. Registrar.

Par

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct. 15. 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 2, 1927, to Oct 14, 1927, that I last saw h alive on Oct 14, 1927, and that death occurred, on the date stated above, at 4 P M. The CAUSE OF DEATH* was as follows:

(a) Organic Heart Disease

Contributory

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) C. Hampton Jones M. D.

Oct 16. 1927 (Address) 1534 N. Eutaw St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvary — DATE OF BURIAL: 10/18/27

20-UNDERTAKER: Mrs S. E. Elliott — ADDRESS: 725 Eastlund Ave

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19113
1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

31

E 19113
REGISTERED NO.

City of BALTIMORE: (No. 1615 Abbott St., 712 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Reed

(a) RESIDENCE NO. 1615 Abbott St. Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: C

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elijah Reed

6 DATE OF BIRTH (month, day, and year): Sept 15 1901

7 AGE: Years 25 | Months 4 | Days 29 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laundress
(b) General nature of industry, business, or establishment in which employed (or employer): Home
(c) Name of employer

9 BIRTHPLACE (city or town): Kent County
(State or country)

PARENTS

10 NAME OF FATHER: John Stanley

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Md

12 MAIDEN NAME OF MOTHER: Sarah Pinkard

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Md

14 Informant: Elijah Reed
(Address): 1615 Abbott

Filed FEB 17 1927 C. HAMILTON JONES, M. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927: Feb 14

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1927, to Feb 14, 1927, that I last saw h[illegible] alive on Feb 14, 1927, and that death occurred, on the date stated above, at 10 45 m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary): Abdominal Phthisis.

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? Unk

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

Feb 16 1927 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Auburn Date of Burial 2/17/27

20 UNDERTAKER: Wm. P. A. Elliott ADDRESS 1725 Eastland

Very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19114

## CERTIFICATE OF DEATH.

40 E 19114

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Baltimore Gen. Hosp ST. 1-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Williams

(a) RESIDENCE No. 562 N. Mary's ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Williams

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE: Years 41 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shoe worker 023

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Harry Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Matilda Reason

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) West Baltimore Gen. Hosp Records

15 Filed AUG 17 1927 19 By C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/15 1927

17 I HEREBY CERTIFY, That I attended deceased from 1/8, 1927, to 2/15, 1927, that I last saw h[illegible] alive on 2/15, 1927, and that death occurred, on the date stated above, at 1 05 P m.

The CAUSE OF DEATH* was as follows:

Cerebral thrombosis generalized

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes, Date of 2/12/27

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) Amos L Jones, M. D.

2/16, 1927 (Address) West Balt. Gen. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem. — DATE OF BURIAL: 2/18/27

20 UNDERTAKER: Wm A. Elliott — ADDRESS: 1220 Ashland Av

Spec.—1-12-23—M&T—506 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19115 — 129 — E 19115

## CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 896 W Baltimore St. 1876 WARD)

2-FULL NAME John D Burch

(a) RESIDENCE NO. 896 W Baltimore St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah E Burch

6 DATE OF BIRTH (month, day, and year): Jan 24 1845

7 AGE: Years 82 | Months | Days 22 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clockmaker 039

(b) General nature of industry, business, or establishment in which employed (or employer): (Retired)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Miss Lillian Burch (Address) 896 W Baltimore

15 Filed 3 17 1927, 19 .... Registrar: H. HAMPSON JONES, M. D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/15/ 1927

17 I HEREBY CERTIFY, That I attended deceased from 3/10/ 1924 to 3/15/ 1927, that I last saw h— alive on 3/15/27, 19 ..., and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Art Sclerosis - Chronic Myocarditis - Acute Dilatation

(duration) — yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Benj. J. Terry, M. D.

3/16/ 1927 (Address) 910 W. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters Cemetery — DATE OF BURIAL: 3/18 27

UNDERTAKER: George A Farley — ADDRESS: Fulton & Fayette

Spec.–7-17-26—A Co.—200 Bks.

E 19116

# HEALTH DEPARTMENT—CITY OF BALTIMORE

160 E 19116

## CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3310 Foster Ave. St., 7th-2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theodore Dreyfler.

(a) RESIDENCE NO. 3310 Foster Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 10-1927

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..hrs. or ..min.. |
|---|---|---|---|---|
| ✓ | ✓ | ✓ | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER John Dreyfler.

11 BIRTHPLACE OF FATHER (City or town) Balto.

(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Ebauer.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany.

14 Informant John Dreyfler.

(Address) 3310 Foster Ave.

15 FEB 17 1927 C. HAMPSON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 16-1927

17 I HEREBY CERTIFY, That *I attended deceased from Feb. 11, 1927, to Feb. 17, 1927, that I last saw h[illegible] alive on Feb. 17, 1927, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Congenital debility

Twin birth

(duration) yrs. mos 6 ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) 806 S. 3rd St.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem. Date of Burial Feb. 17th 1927

20 UNDERTAKER Lilly & Zeile ADDRESS 403 S. Wolfe St.

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 19117

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129 E 19117

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1520 E Monument ST., 7-13 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura J Robinson

(a) RESIDENCE NO. 1520 E Monument ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John A. Robinson

6 DATE OF BIRTH (month, day, and year): 1865

7 AGE: Years 62; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Savannah Ga

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Clara Robinson (Address) 1520 E Monument St

15 Filed 3-7-1927, 19 HAMILTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 15 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 4, 1927, to Feb 15, 1927, that I last saw h[illegible] alive on Feb 15, 1927, and that death occurred, on the date stated above, at 12.50 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorrhage

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary): Hypertension and Nephritis

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) R J Gourley, M. D.

2-17 1927 (Address) 1429 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Lawn

DATE OF BURIAL: 3/7/27

20 UNDERTAKER: Samuel Hensley

ADDRESS: 1128 Biddle St.

Spec.—1-12-23—M&T—500 Blks.

E 19118 HEALTH DEPARTMENT—CITY OF BALTIMORE E 19118

## CERTIFICATE OF DEATH.

91-002

1-PLACE OF DEATH Hebrew Immigrant Home

CITY OF BALTIMORE: (No. 2100 E Balto St ST., 6-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Ezersky

(a) RESIDENCE No. 3 N. Ann Street ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., If of foreign birth? 6 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | W | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 104 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Old age

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jacob Lewis

(Address) 1439 E Balto St

Filed FEB 17 1927 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/17 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 18, 1926, to Feb 17, 1927, that I last saw h[illegible] alive on Feb 16, 1927 and that death occurred, on the date stated above, at 10 a m

The CAUSE OF DEATH* was as follows:

Senile Debility

(duration) 20 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) 1810 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Cemetery DATE OF BURIAL 2/17 1927

20 UNDERTAKER Jacob Lewis ADDRESS 1439 E Balto St

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19119

## CERTIFICATE OF DEATH.

10-E 19119

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital St., 1-3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Sporan

(a) RESIDENCE NO. 620 S. Rose St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 0 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 7, 1925

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 2 | 0 | 10 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Andrew Sporan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Eliz. Juntek

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Andrew Sporan

(Address) 620 S. Rose St.

15 Filed FEB 17 1927 C. HAMILTON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 16 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb. 11, 1927, to Feb 16, 1927, that I last saw him alive on Feb 16, 1927, and that death occurred, on the date stated above, at 8 25 P m.

The CAUSE OF DEATH* was as follows:

Laryngeal & Pharyngeal Diphtheria

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Intubated Date of 2/12/27

Was there an autopsy? No

What test confirmed diagnosis? Clinical Spec. Ex. Culture

(Signed) Myron G. Tull, M. D.

2/17 1927 (Address) Sydenham Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus Cem DATE OF BURIAL Feb 17 1927

20 UNDERTAKER Stephen J. Fialkowski ADDRESS 1520 Fleming St

Spec.—1-10-21—M&T—1500 Bks.

# E 19120 HEALTH DEPARTMENT—CITY OF BALTIMORE

100 E 19120

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1231 Druid Hill Ave Street) 11-24 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Beulah Reid Hardy

(a) RESIDENCE NO. 1231 Druid Hill Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divnrced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John S. Hardy

6 DATE OF BIRTH (month, day, and year) — — 1865

7 AGE: Years 62; Months —; Days —; If LESS than 1 day, hrs or min. —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of Industry, business, or establishment in which employed (or employer): Gpo

(c) Name nf employer

9 BIRTHPLACE (city or town) (State or country): Columbus Georgia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): " "

12 MAIDEN NAME OF MOTHER: "

13 BIRTHPLACE OF MOTHER (city or town) (State or country): " "

14 Informant: Charles E. Reid

(Address): 1305 Madison Ave

15 Filed AUG 17 1927 19

C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 15, 1927

17

I HEREBY CERTIFY, That I attended deceased from 4/11, 1927, to Feb 15, 1927,

that I last saw her alive on Feb. 14th, 1927,

and that death occurred, on the date stated above, at 11:20 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Fecal Debility

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. Lee Chew, M. D.

2/15, 1927 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: Feb 18 1927

UNDERTAKER: Sam'l H. Chase & Son

ADDRESS: 400 Mad[illegible]

Spec.—6-9-19—H. P. Co.—1000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19121

## CERTIFICATE OF DEATH.

46

E 19121

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 524 N. Eutaw St. 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Della F. Jordan

(a) RESIDENCE. NO. 524 N. Eutaw St. Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 26-80

7 AGE: Years 46 Months 7 Days 20 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): N. C.

PARENTS

10 NAME OF FATHER: Darius White

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. C.

12 MAIDEN NAME OF MOTHER: Phyllis Cox

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. C

14 Informant: P. J. Jordan

(Address): 524 N. Eutaw

15 Filed B 17 1927 W. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 15 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 15 1927 to Feb 15 1927

that I last saw her alive on Feb 15 1927

and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Cancer of Uterus

(duration) 1 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Mar 24 1926

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Thos Woodruff M. D.

(Address) 703 Whitelock

July 7 1927

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Zion

DATE OF BURIAL: Feb 18 1927

20 UNDERTAKER: Sam'l W. Chase & Son

ADDRESS: 1400 Mosher

Spec–12-23-21–E.B.R.S.–400 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19122

## CERTIFICATE OF DEATH.

74-001

E 19122

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2311 N. Fremont St., 16-68 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine M. Kellow

(a) Residence No. 2311 N. Fremont St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

| 3-SEX. | 4-COLOR OR RACE. | 5-Single, Married, Widowed, or Divorced, (Write the word.) |
|---|---|---|
| F | W | Widow |

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of James M Kellow

6-DATE OF BIRTH (month, day and year) Aug 26 54

7-AGE. 72 yrs. 6 mos. 19 ds.

If LESS than 1 day. ....hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Home 037

(b) General nature of industry, business, or establishment in which employed (or employer)... Work at Home

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), N. Y.

PARENTS.

10-NAME OF FATHER, George Miller

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Eng. Scotland

12-MAIDEN NAME OF MOTHER, Sarah Watson

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Scotland

14-(Informant) E. Corinne K Coulshafter

(Address) 2311 N. Fremont St

15-Filed 7 1927 C. HAMPSON JONES, M. D. Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 15 27

17- I HEREBY CERTIFY, That I attended deceased from 2-16, 1927, to 2-15, 1927, that I last saw h.. alive on 2-15, 1927, and that death occurred, on the date stated above, at 8 A. m.,

The CAUSE OF DEATH* was as follows:

Hemorrhage in internal capsule of Left Brain (Hemiplegia)

(Duration) yrs. mos. 13 hrs

CONTRIBUTORY (Secondary) Arterial Sclerosis

(Duration) 2 yrs. mos. ds

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Paralysis of R side & coma

(Signed) Thos. H Kelly M. D

, 19 (Address) 2300 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19-PLACE OF BURIAL, CREMATION OR REMOVAL. | DATE OF BURIAL. |
|---|---|
| Rural Burial Brookview Cem | Feb 18 1927 |
| 20-UNDERTAKER. | ADDRESS |
| W M Rowton | 2238 N Arlington |

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19123

100-001

## CERTIFICATE OF DEATH.

17-25

E 19123

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 640 W. Montgomery St., ____ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Allen

(a) RESIDENCE NO. 640 W. Montgomery St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. ____ mos. ____ dys. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ dys.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Col, | single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar. 1921

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 5 | 11 | (?) | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Newport News

(State or country) Va,

PARENTS

10 NAME OF FATHER Albert White

11 BIRTHPLACE OF FATHER (city or town) ____

(State or country) Va,

12 MAIDEN NAME OF MOTHER Mable Allen

13 BIRTHPLACE OF MOTHER (city or town) ____

(State or country) Va,

14 Informant Mable Allen

(Address) 640 W. Montgomery

15 Filed 7 1927 C. HAMPSON JONES, M. D. Registrar

Per ____

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 17 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 14, 1927, to Feb 17, 1927, that I last saw h.. alive on Feb 16, 1927, and that death occurred, on the date stated above, at 7 1 m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia (Primary)

(duration) ____ yrs. ____ mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of ____

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) D. Hampson, M. D.

2/17 1927 (Address) 805 Mary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary — Date of Burial 2-19-27

20 UNDERTAKER John H. Soadin — ADDRESS 1027 Monument

Very Important. See Instructions on Back of Certificate.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19124 E 19124

## CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Woodburne Ave. St. Ward)

2-FULL NAME Eldridge H Riley

(a) RESIDENCE NO. Woodburne Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 3 - 1926

7 AGE: Years / Months 3 / Days 13 / IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Thos. H Riley

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Emma DeFarney

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Illinois

14 Informant Thos H. Riley

(Address) Woodburne Ave

15 Filed 7 1927 By C. HAMPSON JONES, M. D. Registrar Rees

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 16th 1927

17 I HEREBY CERTIFY, That I attended deceased from Feby 12/27, 1927, to Feby 16, 1927, that I last saw him alive on Feby 16, 1927, and that death occurred, on the date stated above, at 3.55 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Lobar)

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) La Grippe

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. H. Duncan, M. D.

Feb 17. 1927 (Address) 5106 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Joseph Cathy Hill — Date of Burial 2/18 1927.

20 UNDERTAKER: Wm Cook — ADDRESS 502 E North Ave

Very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19125

101-001

E 19125

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mercy Hospital 12-51

City of BALTIMORE: (No. ____ St. ____ Ward)

REGISTERED NO. ____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Walter Richfield

(a) RESIDENCE NO. 2126 Oak St. St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Married |

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Sydna G Richfield

6 DATE OF BIRTH (month, day, and year) Aug 10, 1877

| 7 AGE Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|
| 49 | 6 | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Male nurse

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Washington D.C.

(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) unknown

(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown

(State or country)

14 Informant Sydna Richfield

(Address) 2126 Oak St

15 Filed ____ 19 ____ C. HAMPSON JONES M. D. Registrar

Rec'r ____

7 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 Mercy Hospital Feb 16.

17 I HEREBY CERTIFY, That I attended deceased from 1-10, 1927, to 2-16, 1927, that I last saw him alive on 2-16, 1927, and that death occurred, on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows: Pneumonia Primary

2 wks.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Uremia 2 weeks

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? ____

Did an operation precede death? No Date of ____

Was there an autopsy? No

What test confirmed diagnosis? ____

(Signed) E. Passing, M. D.

, 19 (Address) ____

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — Date of Burial 2/19 1927

20 UNDERTAKER Wm Cook — ADDRESS 502 E Fayette

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

(Gutierrez) ✓

199847
E 19126

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19126

58-002

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 2-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Esa - Guttiarez

(a) RESIDENCE No. 101 E - Anne St - ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 4 1927

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min |
|---|---|---|---|---|
| | | 1 | 14 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md -

PARENTS

10 NAME OF FATHER Frank Gutierrez

11 BIRTHPLACE OF FATHER (city or town) (State or country) Spain

12 MAIDEN NAME OF MOTHER Anna McBald

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa -

14 Informant Record

(Address) JOHNS HOPKINS HOSPITAL

15 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 16 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb - 2, 1927, to Feb 16, 1927, that I last saw h-e alive on Feb 16, 1927 and that death occurred, on the date stated above, at 10 00 P.M.

The CAUSE OF DEATH* was as follows:

Primary anaemia (Type undetermined)

(duration) yrs. 1 mos. 12 ds.

CONTRIBUTORY (Secondary) Meningitis (Pneumococcus)

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? 101 E. Anne St.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy.

(Signed) H. E. Handley, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Cemetery DATE OF BURIAL: Feb 18 1927

20 UNDERTAKER: Wendell Hippler ADDRESS: 37 E Anne

Spec.—1-12-23—M&T—500 Bks.

2E 07 7
2E 19127

# HEALTH DEPARTMENT—CITY OF BALTIMORE E 19127

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL St. 7-9 Ward)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME J. Leslie Robinson

(a) RESIDENCE NO. Rainelle W. Va. St. WARD
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1903

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min |
|---|---|---|---|---|
| | 24 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk - 009

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Va

PARENTS

10 NAME OF FATHER Elasis Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va

12 MAIDEN NAME OF MOTHER Ebra Hazelett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Va

14 Informant Records
(Address)

15 Filed 7 1927 JOHNS HOPKINS HOSPITAL C. HAMPSON JOBES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 17 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 9, 1927, to Feb 17, 1927, that I last saw him alive on Feb 17, 1927 and that death occurred, on the date stated above, at 2 05 P. m.

The CAUSE OF DEATH* was as follows:

Tbc. Meningitis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Tbc of Kidney

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Milton Aberg, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Rosecrosse W Va | 2/17/27 |
| 20 UNDERTAKER | ADDRESS |
| Joseph Abrens | 221 Barry |

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19128 E 19128

## CERTIFICATE OF DEATH.

10-14 100-01

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 927 Aisquith St. 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sabatino Bandera

(a) RESIDENCE NO. 927 Aisquith St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 8/26

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 1 | 1 | 8 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Lorenzo Bardena

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Italy

12 MAIDEN NAME OF MOTHER Gretna Banara

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Italy

14 Informant Lorenzo Bandera

(Address) 927 Aosquith St.

15 Filed C. HAMPSON JONES, M. D.

1927 Per Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 Feb 10/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, Autopsy or Inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Broncholneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. S. J. Paca M. D.

(Coroner)

19 (Address) 509 E. North Ave 2/17/27

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Vincent

Date of Burial Feb 18 1927

20 UNDERTAKER Thos E Cochran

ADDRESS 1900 Eutaw Place

Very Important: See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19129

## CERTIFICATE OF DEATH.

129 E 19129

1-PLACE OF DEATH

City of BALTIMORE: (No. 423 E 23rd St 12-50 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest A Kelly

(a) RESIDENCE NO. 423 E 23rd St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma A Kelly

6 DATE OF BIRTH (month, day, and year): Sept 27 1880

7 AGE: Years 46 Months 4 Days 18 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic work

(b) General nature of industry, business, or establishment in which employed (or employer): no

(c) Name of employer: no

9 BIRTHPLACE (city or town)

(State or country): Va.

PARENTS

10 NAME OF FATHER: Spencer Patterson

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Jane Scott

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md.

14 Informant: Ernest A. Kelly

(Address): 423 E 23rd St

Filed FEB 7 1927

C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 15 1927

17

I HEREBY CERTIFY, That I attended deceased from Nov 20 1926, to Feb 15 1927, that I last saw h alive on Feb 15 1927, and that death occurred, on the date stated above, at 3.40 pm

The CAUSE OF DEATH* was as follows:

Acute Nephritis and Uremia

Insufficiency

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) yrs. ? mos. ? ds.

18 Where was disease contracted

If not at place of death! Unknown

Did an operation precede death! no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) E. E. Kelly, M. D.

, 19 (Address) 423 E 23rd St

*State the Disease Causing Death, or if death from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery Date of Burial 2/18/19 27

20 UNDERTAKER: Wm. Geo. E. Holland ADDRESS: 1631 Druid Hill Ave

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19130

## CERTIFICATE OF DEATH.

E 19130

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1010 S. Fremont St., 16-23 31 Ward)

2-FULL NAME Susie Jones

(a) RESIDENCE NO. 1010 S. Fremont St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Fe | Col | Widow |

5a If married, widowed, or ~~divorced~~ ~~HUSBAND of~~ (or) WIFE of Wm Jones

6 DATE OF BIRTH (month, day, and year) Oct. 1888

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 38 | 4 | (?) | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housework

(b) General nature of industry, business, or establishment in which employed (or employer) home

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) N. C.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) unknown

14 Informant L. Stanard

(Address) 1010 S. Fremont

Filed FEB 18 1927 G. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 16 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 11 1927, to Feb 16, 1927, that I last saw h.. alive on Feb 16, 1927, and that death occurred, on the date stated above, at 3.40 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 5 mos. 5 ds.

CONTRIBUTORY _____

(Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted _____

If not at place of death? _____

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis? _____

(Signed) G. H. Hampson, M. D.

2/16 1927 (Address) 801 Mays St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

Date of Burial 2, 18 1927

20 UNDERTAKER Mrs Geo H Hooper

ADDRESS 406 W Conway

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19131

## CERTIFICATE OF DEATH.

74-501

E 19131

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2124 W. Fayette St. 6-10 WARD)

2-FULL NAME Lanna Hudson

(a) RESIDENCE NO. 2024 W. Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 22 1852

7 AGE

| Years | Months | Days | If LESS than 1 day, ....hrs. or ....min. |
|---|---|---|---|
| 74 | 10 | 24 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER L. W. Hinton

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Lanna Hinton

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Mrs. R. Hudson

(Address) 2124 W. Fayette St.

15 Filed FEB 8 1927 C. HAMPSON JONES, M. D. Registrar

Per R.M.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/16/1927

17

I HEREBY CERTIFY, That I attended deceased from Feb 7, 1927, to 2-14-, 1927,

that I last saw h[illegible] alive on 2-14-, 1927,

and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Hemaplegia —

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? ✓

What test confirmed diagnosis? Clinical

(Signed) R. Heller Hemming M. D.

2/18, 1927 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

DATE OF BURIAL: 2/18 1927

20 UNDERTAKER: Robert Brockbank

ADDRESS: Fulton & Hollins

Spec.—1-12-23—M&T—500 Blks.

E 19132

# HEALTH DEPARTMENT—CITY OF BALTIMORE

90

E 19132

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1515 E. Pratt St. St., 2-11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachael Schmaltzer

(a) RESIDENCE NO. 1515 E Pratt St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | W | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Schmaltz

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 73 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mrs. Schmaltzer (Address) 1515 E Pratt St

15 Filed 3 1-8 1927 T. HAMPSON JONES, M. D. Registrar Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/18 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 15, 1927 to Feb 18, 1927

that I last saw her alive on Feb. 18, 1927

and that death occurred, on the date stated above, at 1a m

The CAUSE OF DEATH* was as follows:

Chron Myocarditis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Grippe, Bronchitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. J. Baylin M. D.

2/18/27 (Address) 2048 Eulaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Lehren Rosedale | 2/18 1927 |

20 UNDERTAKER Jack Lewis ADDRESS 1439 E Balt St

Spec.—1-12-23—M&T—500 Blks.

300 148 E 19133

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

+ 41 E 19133

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ) ST. 7-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Hall

(a) RESIDENCE NO. Essex & Eastern Ave - ST. Stevenson Run - Md -

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | white | — |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | | 4 - | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ....— did

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md -

PARENTS

10 NAME OF FATHER Edward Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md -

12 MAIDEN NAME OF MOTHER Catherine Whigington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records - (Address) JOHNS HOPKINS HOSPITAL

15 Filed 1 8 1927 C. HAMPSON JONES, M. D. Registrar R. K.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 17 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 11, 1927, to Feb 17, 1927, that I last saw her alive on Feb 17, 1927 and that death occurred, on the date stated above, at 1 45 a.m.

The CAUSE OF DEATH* was as follows:

Streptococcus Septicaemia

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Essex & Eastern Ave

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) H. E. Handley, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cemetery

DATE OF BURIAL Feb 18th 1927

20 UNDERTAKER Lilly & Zeiler

ADDRESS 408 S. Wolfe St

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19134

## CERTIFICATE OF DEATH.

100-002

E 19134

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1104 Argyle St. [illegible] Ward)

2-FULL NAME Thelma Floyd

(a) RESIDENCE NO. 1104 Argyle St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1 yr. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: child

6 DATE OF BIRTH (month, day, and year): Jan. 7, 1927

7 AGE — Years: — Months: 1 — Days: 9 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: [illegible]

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto.

(State or country): Md.

PARENTS

10 NAME OF FATHER: Emanuel Floyd

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Va.

12 MAIDEN NAME OF MOTHER: Helen Murray

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country): Md.

14 Informant: Helen Floyd

(Address): 1104 Argyle Ave.

Filed FEB 18 1927 C. HUBERT JONES, M.D. Registrar

Per [signature]

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 16 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cap. Bronchitis.

(duration) 1 yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. 1 mos. 6 ds.

Feb 18 1927 (Signed) J. C. Yates M. D.

(Coroner)

(Address) 143 W. Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Zion Cemetery — Date of Burial: Feb. 18, 1927

20 UNDERTAKER: Mrs. Katie R. Williams — ADDRESS 322 N. Schroeder St

Key important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19135

## CERTIFICATE OF DEATH.

101-001

E 19135

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 317 S. 12th. ST., 26-37 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doris M. Miller

(a) RESIDENCE NO. 317 S. 12. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): 1/5/1927

7 AGE — Years: — Months: 1 Days: 11 If LESS than 1 day, .... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Albert Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Astonia,

12 MAIDEN NAME OF MOTHER: Lillian Sage

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: Albert Miller (Address) 917 S 12th St

15 Filed 1-6-1927 C. HAMPSON JONES, M. D. Registrar Per RL

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feby 16 1927

17 I HEREBY CERTIFY, That I attended deceased from Feby 10, 1927 to Feby 16, 1927. that I last saw h[illegible] alive on Feby 16, 1927 and that death occurred, on the date stated above, at 8 30 P. m.

The CAUSE OF DEATH* was as follows:

Double pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Asphyxia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Sx

(Signed) Dr L Hollins, M. D.

Feby 19 24 (Address) 224 E 39

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel

DATE OF BURIAL: Feby 18 1927

20 UNDERTAKER: John Ellis

ADDRESS: 2108 Orleans

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19136

## CERTIFICATE OF DEATH.

11-001

E 19136

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 224 N Collington Ave 6-10 WARD)

2-FULL NAME John B Mc Cardell

(a) RESIDENCE NO. 224 N Collington ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louise Waller

6 DATE OF BIRTH (month, day, and year): Jan 4-1897

7 AGE: Years 30 Months 1 Days 12 If LESS than 1 day, .... hrs. or .... min. 11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): New York

PARENTS

10 NAME OF FATHER: Frank McCardell

11 BIRTHPLACE OF FATHER (city or town) (State or country): New York

12 MAIDEN NAME OF MOTHER: Dora Linn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Dont Know

14 Informant: Mrs Louise M Cardell

(Address): 224 N Collington Ave.

15 Filed FEB 16 1927, 19 C. HAMILTON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feby 16 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb 14, 1927, to Feb 16, 1927, that I last saw h[illegible] alive on Feb 16, 1927, and that death occurred on the date stated above, at 3 05 a.m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Acute Tonsilitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) Fred Renatta M. D.

2-17-27 (Address) 800 N Wolfe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem

DATE OF BURIAL: Feby 19 1927

UNDERTAKER: D Johnemeier

ADDRESS: 28 Orleans

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19137

## CERTIFICATE OF DEATH.

90 E 19137
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 232 N. Milton Ave ST. 6-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Schmidt

(a) RESIDENCE NO. 232 N. Milton Ave ST., ... WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 3 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M. | W. | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Schmidt

6 DATE OF BIRTH (month, day, and year) Nov 13 1866

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or ... min. |
|---|---|---|---|---|
| | 60 | 3 | 3 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Produce

(c) Name of employer W. E. Jones Co.

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Nicholas Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Bergie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Anna Schmidt
(Address) 232 N Milton Ave

15 8 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 16 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 6 1927 to Feb 16 1927, that I last saw him alive on Feb 15 1927, and that death occurred, on the date stated above, at 5.10 A m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Jacob Frahm I, M. D.

2/16, 1927 (Address) 1823 N. Wash St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery — DATE OF BURIAL Feby 19 1927

20 UNDERTAKER John Meerist — ADDRESS 918 Eutaw

Cor.—12-9-25—A Co.—200 Bks.

E 19138

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19138

100-09

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1410 N. Parrish St. 15-21 Ward)

2-FULL NAME Alfonso Murdock.

(a) RESIDENCE NO. 1410 N. Parrish St. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2/ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2/1/27

7 AGE: Years — Months — Days: 15

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None (M)

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Md.

PARENTS

10 NAME OF FATHER Robt. Murdock

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Green

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Ga.

14 Informant Mary Murdock

(Address) 1410 N. Parrish St.

15 Filed....., 19..... G. HANSON JONES, M.D.

Registrar

FEB 18 1927

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 16, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ..... yrs. ..... mos. 1/ ds.

CONTRIBUTORY (Secondary) no other history

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D.

(Coroner)

Feb. 17, 1927 (Address) 2507 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ..... mos., ..... ds. In the State ..... yrs., ..... mos., ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cem. Date of Burial 2/18/ 1927

20 UNDERTAKER: E. F. Lakey & Sons ADDRESS 315 Light St.

Why important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Misciwyeski)

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19139 E 19139

## CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 503 S-Dallas ST., 3rd WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Antoni Misciwyeski

(a) RESIDENCE NO. 503 S. Dallas ST., 2 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of W Katherine

6 DATE OF BIRTH (month, day, and year) Not Known

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 41 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Adam Misciwyeski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Ann Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant W Katherine Misciwyeski (Address) 503 S Dallas.

15 Filed FEB 18 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-16- 1927

17 I HEREBY CERTIFY, That I attended deceased from Febry 15, 1927, to Febr 15, 1927, that I last saw him alive on Febry 15, 1927, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Acute Meningitis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Diagnosis

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lumbar Puncture & Urine

(Signed) H. Saunders Ward M. D.

2-17-1927 (Address) 2042 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary

DATE OF BURIAL 2/19 1927

UNDERTAKER Wm Fiaefsowth

ADDRESS 1141 Eastern Ave

Spec.—1-12-23—M&T—500 Bks.

1926 45 E 19140 HEALTH DEPARTMENT—CITY OF BALTIMORE E 19140

# CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL (St.) 22-31 (WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Calvin Charles Howard

(a) RESIDENCE NO. 106 Hughes Ave ST. WARD
(Usual place of abode)
Length of residence in city or town where death occurred 1 yrs. 11 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 4 1925

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min |
|---|---|---|---|---|
| | 1 yrs. | 11 | 13 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ——
(b) General nature of industry, business, or establishment in which employed (or employer) ——
(c) Name of employer ——

9 BIRTHPLACE (city or town) (State or country) Md —

PARENTS

10 NAME OF FATHER Claude C. Howard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md —

12 MAIDEN NAME OF MOTHER Elsie Hughes.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md —

14 Informant Records — (Address) JOHNS HOPKINS HOSPITAL

15 Filed B 1 8 1927 C. HAMPTON JONES, M. D. Registrar
For R.C.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 17 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 2 1927, to Feb 17 1927, that I last saw him alive on Feb 17 1927 and that death occurred, on the date stated above, at 12 45 P.M.

The CAUSE OF DEATH* was as follows:

Septicemia, Staphylococcus aureus
? Osteomyelitis "

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) pneumonia, bilateral bronchopneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? none - 106 Hughes Ave

Did an operation precede death? yes Date of Feb 4

Was there an autopsy? no

What test confirmed diagnosis? blood cultures

(Signed) Warfield M Theobald, M. D.

2/ 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cambridge Md — DATE OF BURIAL: Feb 19 1927

20 UNDERTAKER: John F Demmy — ADDRESS: 715 Light St

Cor.—12-9-25—A Co.—200 Bks.

E19141

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E19141

## CERTIFICATE OF DEATH.

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospital St. 58 Ward)

2-FULL NAME Mary Hammill

(a) RESIDENCE NO. 408 4 Front St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Robert Hammil

6 DATE OF BIRTH (month, day, and year): March 5, 1887

7 AGE: Years 39 Months 11 Days 11 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEDENT

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer

9 BIRTHPLACE (city or town): Maryland

(State or country)

PARENTS

10 NAME OF FATHER: Wm. H. Schubart

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Margaret Warner

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: Oscar D. Sexton

(Address): 3116 Wilkins Ave.

Filed 8 1927 C. HARRISON JONES, M. D.

Per Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 14 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Acute Hepatitis

Congestion of Brain

(duration) .....yrs. .....mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) James M. Taylor M. D.

(Coroner)

2/17 1927 (Address) 700 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death Balto City Hos yrs. mos. ds. In the State yrs. mos. 5 ds.

Where was disease contracted, if not at place of death?

408 N Front St

Former or usual residence 408 N Front St

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Chapico St Mary's Date of Burial Feb. 29 1926

20 UNDERTAKER: E. Leroy Stiffler ADDRESS: 125 E. North Ave

Spec. 7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

13 E 19142

E 19142

## CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. 7-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theresa M. Schell

(a) RESIDENCE NO. 1255 S. Castle St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. How long in U. S. if of foreign birth? 76 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year): April 8 1871

7 AGE: Years 55 Months 10 Days 9 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer): 064

(c) Name of employer

9 BIRTHPLACE (city or town): Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER: Jacob Schell

11 BIRTHPLACE OF FATHER (City or town): Germany

(State or country)

12 MAIDEN NAME OF MOTHER: Margaret Moore

13 BIRTHPLACE OF MOTHER (city or town): Germany

(State or country)

14 Informant: Univ. Hospital Records

(Address) Lombard & Green Sts.

15 FEB 18 1927

19 C. HAMPSON JONES, M. D.

Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 17 1927 10:45 AM

17 I HEREBY CERTIFY, That I attended deceased from 1/18, 1927, to 2/17, 1927, that I last saw h.e.r. alive on 2/17, 1927, and that death occurred, on the date stated above, at 10:45 A.M.

The CAUSE OF DEATH* was as follows:

Pyonephrosis with perinephritic abscess

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulm. myocarditis Bronchio-pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death? Not known

Did an operation precede death? Yes Date of 2-3-27

Was there an autopsy? Yes

What test confirmed diagnosis? Post-mortem

(Signed) Herbert R. Stiles, M. D.

, 19 (Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — Date of Burial: Feb. 21 1927

20 UNDERTAKER: Henry Hoerle & Son — ADDRESS: 1301 E. Eager St.

Very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

Dr Fisher Ex Pat pl Dr

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 19143

REGISTERED NO. 1279 E 19143

1-PLACE OF DEATH

City of BALTIMORE: (No. Volunteer Armories Hosp St., [illegible] Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William A Key

(a) RESIDENCE NO. 223 North Eutaw St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Key.

6 DATE OF BIRTH (month, day, and year): March 4, 1877

7 AGE — Years: 49 — Months: 11 — Days: — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Photographer

(b) General nature of indnstry, business, or establishment in which employed (or employer): 086

(c) Name of employer: Self

9 BIRTHPLACE (city or town): B.

(State or country): D.

PARENTS

10 NAME OF FATHER: E E Key

11 BIRTHPLACE OF FATHER (city or town):

(State or country): D.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Unknown

14 Informant: Mary Key

(Address): 223 N Eutaw St

Filed 1 18 1927 G. HAMPSON JONES, M. D. Registrar

Per R K

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 14 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Central Pregnancy

Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Samuel A Fisher M. D. (Coroner)

, 19 27 (Address) 3825 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cumberland County Md.

Date of Burial: Feb. 19, 1927.

20 UNDERTAKER: W Cook

ADDRESS: 562 E. Hoffman

Spec—12-23-21—E.B.R.S.—400 Bks.

# E 19144 HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 19144

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1606 E. Chase Street St. 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Angeline Zimmerman

(a) Residence No. 1606 E. Chase Street St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

| 3-SEX | 4-COLOR OR RACE | 5-Single, Married, Widowed, or Divorced, (Write the word.) |
|---|---|---|
| Female | White | married |

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Fred B. Zimmerman

6-DATE OF BIRTH (month, day and year) 3 | 12 | 1874

| 7-AGE | If LESS than 1 day, |
|---|---|
| 52 yrs. 11 mos. 3 ds. | ....hrs. or....min.* |

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md.

PARENTS

10-NAME OF FATHER, John Peters

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Mary Peters

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Fred B. Zimmerman

(Address) 1606 E. Chase St

FEB 18 1927 C. HAMPSON JONES, M. D. Registrar.

Per

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 2-15-27

17- I HEREBY CERTIFY, That I attended deceased from 2/1/27, 19 27 to 2/15, 19 27

that I last saw her alive on 2/15, 19 27

and that death occurred, on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Mitral Degeneration

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) David Riggin M. D.

2/27, 1927 (Address) 1500 Broadway

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

| 19-PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL, 2/19, 1927 |
|---|---|
| Holy Redeemer Cemetery | |

UNDERTAKER. George J. Ruth ADDRESS 1735 Harford Ave

Spec. -7-17-26 —A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 19145

REGISTERED NO. 14-004 19145

1-PLACE OF DEATH

City of BALTIMORE: (No. 1633 N Broadway St. 18-7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert N Simpson

(a) RESIDENCE NO. 1633 N. Broadway St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of M. Ella Simpson

6 DATE OF BIRTH (month, day, and year) Aug 12. 1855

7 AGE: Years 71 Months 6 Days 25 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mail Carrier

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer U S Govt

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER James Simpson

11 BIRTHPLACE OF FATHER (City or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mahoney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Ethel R Gibson

(Address) 1633 N. Broadway

15 Filed FEB 18 1927 19 HARRY M. JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 16 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 20, 1926 to Feb. 16, 1927, that I last saw h[illegible] alive on Feb. 16, 1927, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis? Physical Signs

(Signed) Geo. T. Stellen, M. D.

2/17, 1927 (Address) 1937 Douglas

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — Date of Burial: Feb 18, 1927

20 UNDERTAKER: F. M. Cook — ADDRESS: 507 Eutaw

Very important. See instructions on back of certificates.

Spec.–7-17-26–A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19146

## CERTIFICATE OF DEATH

E 19146

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1801 E Lafayette Ave St. 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella K Landru

(a) RESIDENCE NO. 1801 E. Lafayette Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 Color or Race White

5 ~~Single~~, Married, ~~Widowed, or Divorced, (write the word)~~ Married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Walter F. Landru

6 DATE OF BIRTH (month, day, and year) March 14th 1871

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min.. |
|---|---|---|---|---|
| | 55 | 11 | 4 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) Deal Island Md

(State or country)

PARENTS

10 NAME OF FATHER Hughy Hineman

11 BIRTHPLACE OF FATHER (city or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Dix

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Walter F. Landru

(Address) 1801 E Lafayette Ave

15 Filed OCT 8 1927 19 H. HAMDY JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 18th 1927

17 I HEREBY CERTIFY, That I attended deceased from October, 1925, to February 8th, 1927, that I last saw h[illegible] alive on February 18th, 1927, and that death occurred, on the date stated above, at 12:30 m.

The CAUSE OF DEATH was as follows:

Recurrent Carcinoma of Sinus Nasalis Frontal Lipoma of Pelvic Viscera

(duration) yrs. 8 mos. ds.

CONTRIBUTORY Secondary Carcinoma (Secondary)

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 1926

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Howard Sylvester, M. D.

2/8/27 19 (Address) 1211 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Loudon Park Cemetery | 2/18/1927 |
| 20 UNDERTAKER Wm Cook | ADDRESS 502 E. North Ave |

Very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT--CITY OF BALTIMORE

100-006

E 19147

1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

E 19147

REGISTERED NO._____

City of BALTIMORE: (No. Johns Hopkins Hospital St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bernard Sondvick

(a) RESIDENCE NO. 812 S. Kenwood Ave St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 23/26

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | | 8 | 24 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto. Md

PARENTS

10 NAME OF FATHER John Sondvich

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Eliz. Schriver

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant John Sondvich

(Address) 812 S. Kenwood Ave

15 Filed_____ 19____ Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 17/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobular Pneumonia

Autopsy at "opkins

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Otitis Media

(duration) yrs. mos. ds.

(Signed) J. M. Cullen M. D.

(Coroner)

2-17-19 27 (Address) 503 E. [illegible] AVE

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Date of Burial 2/19 19 27

20 UNDERTAKER Wm Cook ADDRESS 502 E North

Very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

1924 E 19148

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19148

## CERTIFICATE OF DEATH.

101-001

1. PLACE OF DEATH
CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 24-35 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Catherine Moreau

(a) RESIDENCE NO. 1424 Reynolds St. ST. WARD
(Usual place of abode)
Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of =

6 DATE OF BIRTH (month, day, and year) Oct 4-1926

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min |
|---|---|---|---|---|
| | | 4 | 13 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS
10 NAME OF FATHER Raymond Moreau
11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.
12 MAIDEN NAME OF MOTHER Ethel Allen
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant
(Address) JOHNS HOPKINS HOSPITAL

15 Filed FEB 18 1927, 19 C. HARRISON JONES, M. D. Registrar
Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 17 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 6, 1927, to Feb 17, 1927, that I last saw her alive on Feb 17, 1927, and that death occurred, on the date stated above, at 9:15 a.m.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(duration) yrs. mos 18 ds.

CONTRIBUTORY (Secondary) Emphysema with bronchial fistula - pyopneumothorax (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Baltimore -
Did an operation precede death? No Date of -
Was there an autopsy? Yes
What test confirmed diagnosis? -
(Signed) H. E. Handley, M. D.
, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem. DATE OF BURIAL Feb 18 1927

20 UNDERTAKER Chas L. Stevens ADDRESS 1501 E Fort Ave

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19149

## CERTIFICATE OF DEATH.

37 E 19149

1-PLACE OF DEATH Union Memorial Hospital.

CITY OF BALTIMORE: (No. 3?rd & Calvert ST. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ralph William Brigerman.

(a) RESIDENCE NO. 1426 Reynold ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Infant |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 19, 1924

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 2 | 8 | 28 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balt., Md.
(State or country)

PARENTS

10 NAME OF FATHER Milton W. Brigerman

11 BIRTHPLACE OF FATHER (city or town) Balt.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Bertha Reinke

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Mrs Hetta Brigerman
(Address) 1426 Reynolds St

15 Filed FEB 18 1927 19 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 17, 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 17, 1927 to Feb 17, 1927.

that I last saw him alive on Feb. 17, 1927.

and that death occurred, on the date stated above, at 5:15 P. m.

The CAUSE OF DEATH* was as follows:

Meningitis (Probably Tuberculous)

(duration) yrs. ? mos ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? Spinal fluid & family history

(Signed) ~~C. H. Jones~~ M. D.

~~Dr. H. O.~~ (Address) Union Mem (Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill

DATE OF BURIAL FEB 18 1927

UNDERTAKER Chas. L. Stevens

ADDRESS 1501 E Fort Ave.

Spec—12-23-21—E.B.R.S.—400 Bks.

Motley

E 19150

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19150

## CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

City of BALTIMORE: (No.) 721 Ensor St., 10-14 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlotte Motley

(a) Residence No. 721 Ensor St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fe

4-COLOR OR RACE, Col

5-~~Single, Married,~~ Widowed, ~~or Divorced,~~ (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John Motley

6-DATE OF BIRTH (month, day and year) ~~Unknown~~ 1876

7-AGE. 51 50 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Virginia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14- (Informant) Mary Smallwood

(Address) 721 Ensor St

15- Filed FEB 18 1927 192 Per C. HAMPSON JONES, M. D. Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb. 17 1927

17- I HEREBY CERTIFY, That I attended deceased from Feb 12 1927 to Feb 17 1927

that I last saw her alive on Feb 17 1927

and that death occurred, on the date stated above, at 11 Pm

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 5 ds

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? Blood and Exam

(Signed) J. Garland Thumlert M. D.

Feb 17, 1927 (Address) 1534 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19-PLACE OF BURIAL, CREMATION OR REMOVAL. | DATE OF BURIAL. |
|---|---|
| Greenville Va | 2/18/27 |
| 20-UNDERTAKER. | ADDRESS |
| Mrs R. C. Elliott | 1725 Eutaw Pl |

E 19151

86

E 19151

# STATE OF MARYLAND
# CERTIFICATE OF DEATH

Registration District No. 43

1 PLACE OF DEATH

County

Village or City Baltimore (No. 40 Norford Rd. St.) (Ward 27) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Amanda Priscilla Dickinson 60 yrs

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widow

6 DATE OF BIRTH: May 27 1843 (Month) (Day) (Year)

7 AGE: 83 yrs. 8 mos. 22 ds. If LESS than 1 day ... hrs. or ... min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or establishment in which employed or (employer)

PARENTS

9 BIRTHPLACE (State or country): Maryland

10 NAME OF FATHER: William Taylor

11 BIRTHPLACE OF FATHER (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary Roberts

13 BIRTHPLACE OF MOTHER (State or country): Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas. Hueler

(Address) 40 Norford Rd. Balto City

15 Filed ... 192... Registrar

C. H. THOMPSON JONES, M. D.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Feby 18 1927 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Feby 15 1927 to Feby 18 1927 that I last saw her alive on Feby 17 1927 and that death occured on the date stated above, at 4.40 a.m.

The CAUSE OF DEATH * was as follows:

Acute myocarditis

(Duration) yrs. ... mos. 4 ds.

Contributory Secondary: Acute Gastritis

(Duration) yrs. ... mos. 4 ds.

(Signed) Morris B. Green M. D.

Feby 18 1927 (Address) Hamilton Baltimore Md.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Feby 21 1927

20 UNDERTAKER: G. F. Alexander

ADDRESS: Eldorado Md.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

1927

CLERK should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19152

## CERTIFICATE OF DEATH

57 E 19152

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hosp. St. 13-52 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Palmer

(a) RESIDENCE NO. 604 W 36th St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Louie Palmer.

6 DATE OF BIRTH (month, day, and year): Sept 27 1865

7 AGE: Years 61 Months 4 Days 17

If LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lineman on R.R.

(b) General nature of industry, business, or establishment in which employed (or employer): R R

(c) Name of employer

9 BIRTHPLACE (city or town): md.

(State or country)

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (City or town): Unknown

(State or country)

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): Unknown.

(State or country)

14 Informant: Wm L. Palmer.

(Address) 2934 Cedar Ave.

FEB 18 1927 C. HAMPSON JONES, M. D. Registrar

Per R K

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 16 19 27

17 I HEREBY CERTIFY, That I attended deceased from June 11, 19 27 to Feb 16, 19 27

that I last saw h alive on Feb 16 19 27

and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

Artus Sclerosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bron Chro-Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. H. Bel City M. D.

, 19 Address University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Market Balto Co.

UNDERTAKER: Chenoweth Bros.

Date of Burial: Feb 19 19 27

ADDRESS 3615 Chestnut Ave.

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19153

## CERTIFICATE OF DEATH.

10 E 19153

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST. 11-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Neal Berotf

(a) RESIDENCE NO. 625 N. Calvert St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 0 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 19, 1926

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 1 | 0 | 28 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Paul Berotf

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Eliz. Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Y.

14 Informant Mrs. Paul Berotf

(Address) 625 N Calvert St

15 Filed FEB 18 1927 19 C. HAMPTON JONES, M.D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 17 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 24, 1927, to Feb 17, 1927, that I last saw him alive on Feb. 17, 1927, and that death occurred, on the date stated above, at 8 30 m

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(duration) yrs. mos 27 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Intubated Date of 1/25/27

Was there an autopsy? No

What test confirmed diagnosis? Clinical - Positive Cult-

(Signed) Myron G. Tull, M. D.

2/18 1927 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary's Hampden DATE OF BURIAL Feb 18 1927

20 UNDERTAKER Schwarzett & Son ADDRESS 3615 Eastern Ave

Spec.–7-17-26—A Co.—200 Bks.

E 19154

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

2-4129

E 19154

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 607 S. Bond St., 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Knobbe

(a) RESIDENCE NO. 607 S. Bond St. 3 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S. if of foreign birth 70 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Josephine Knobbe

6 DATE OF BIRTH (month, day, and year): 1856

7 AGE: Years 70 Months Days IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Dont Know

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Josephine Knobbe (Address) 607 S. Bond St. (Wife)

15 Filed ....., 19.. By ..... Registrar

C. RAWSON JONES M.D.

FEB 8 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 17 19 27

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 19.., to Feb 17, 19.., that I last saw h[illegible] alive on Feb 16, 19.., and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

..... (duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Dont Know

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinic

(Signed) C. Rawson Jones, M. D.

Feb. 18 19 27 (Address) 2938 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cemetery Date of Burial Feb 19 1927

20 UNDERTAKER: Lilly + Zeiler ADDRESS 4036 Wolfe St

Very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19155

161-002

## CERTIFICATE OF DEATH.

E 19155

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore Gen. Hosp. St. 24-33 Ward)

2-FULL NAME William Oliver Baby Boyer

(a) RESIDENCE NO. Severna Park Md. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Feb 14-1927

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | | | 3 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland.

PARENTS

10 NAME OF FATHER Wm. O. Boyer

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Mary Albert

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland.

14 Informant

(Address)

C. HAMPSON JONES M. D.

Registrar

FEB 8 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Feb 17 27

17 I HEREBY CERTIFY, That I attended deceased from Feb 14, 19 27, to Feb 17, 19 27

that I last saw h[illegible] alive on Feb 17, 19 27

and that death occurred, on the date stated above, at 5 30 P. m.

The CAUSE OF DEATH* was as follows:

Intracranial Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Spinal puncture

(Signed) H. C. Miller, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL Date of Burial 19

20 UNDERTAKER ADDRESS

Commissioner Health

FEB 16 1927

Per. Wm. [illegible]

Spec.—12-9-26—A Co.—200 Bks.

E 19156

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 19156

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Kane

(a) RESIDENCE NO. 1225 East Madison Ave St. Balto Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Col | Baby |

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 1926

| 7 AGE Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|
| 4 mos. | 4 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md

PARENTS

10 NAME OF FATHER William Kane

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Lucy Keaton

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed C. HAMPSON JONES, M. D. Registrar

No. 1058

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb 4, 1927, to Feb 14, 1927, that I last saw h[illegible] alive on Feb 14, 1927, and that death occurred, on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Pertussis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Pneumonia (Broncho

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Pure Ex

(Signed) H. E. Hamberger, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL Date of Burial 19

20 UNDERTAKER ADDRESS

Commissioner Health

FEB 18 1927

FEB 18 1927

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19157

161-002

E 19157

## CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital. St. 17-24 Ward)

2-FULL NAME Baby Williams

(a) RESIDENCE NO. 526 W. Lanvale St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 Color or Race Black

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 12, 1927

| 7 AGE | Years | Months | Days | IF LESS than 1 day 10 hrs. or .....min. |
|---|---|---|---|---|
| | | | one | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) .....

(State or country) Md.

PARENTS

10 NAME OF FATHER William King

11 BIRTHPLACE OF FATHER (city or town) ?

(State or country)

12 MAIDEN NAME OF MOTHER Eleanor Williams

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) Md.

14 Informant Off. Williams

(Address) Johns Hopkins Hospital.

15 Filed _____, 19__ C. HAMPSON JONES, M. D. Registrar

B 1927 1057 RRH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 13 19 27

17 I HEREBY CERTIFY, That I attended deceased from Feb. 12, 1927, to Feb. 13, 1927, that I last saw him alive on Feb. 13, 1927 and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) .....yrs. .....mos. 1 ds.

CONTRIBUTORY .....

(Secondary)

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Lumbar Puncture

(Signed) Off. Williams, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL Date of Burial 19

20 UNDERTAKER ADDRESS

Commissioner of Health

FEB 18 1927

Dep. Reg. [illegible]

Spec.—12-9-25—Co.—200 Bks.

99 6 73

E 19158

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

100-001

E 19158

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 16-22 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gil Chesley

(a) RESIDENCE NO. 930 Vincent St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1-22-27

7 AGE — Years: — Months: — Days: 23 18 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Baltimore

PARENTS

10 NAME OF FATHER Ben Chesley

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Gray

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Md

14 Informant Records.

(Address) JOHNS HOPKINS HOSPITAL

Filed ..... 19 .....

8 1927 56 MRH Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 Feb. 15

17 I HEREBY CERTIFY, That I attended deceased from Jan. 27, 1927, to Feb 15, 1927, that I last saw h.. alive on Feb 15, 1927, and that death occurred, on the date stated above, at 10.30 m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Prematurity

(duration) ..... yrs. ..... mos. 15 ds.

18 Where was disease contracted

If not at place of death!

Did an operation precede death! No Date of

Was there an autopsy!

What test confirmed diagnosis!

(Signed) H. E. Handley, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

JOHNS HOPKINS HOSPITAL

Baltimore Health

FEB 19 1927

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19159

100-001

E 19159

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St. 10-28 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. McGann

(a) RESIDENCE NO. 1654 Ashton St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 5-1895

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 32 | 1 | 12 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Reporter do

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) .....

(State or country) England

PARENTS

10 NAME OF FATHER Carpia McGann

11 BIRTHPLACE OF FATHER (city or town) .....

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Marie Ryan

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) England

14 Informant (Address) Records

BALTIMORE CITY HOSPITALS

FEB 8 1927 19 H. HAMILTON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 17 1927

17. I HEREBY CERTIFY, That I attended deceased from February 14, 1927, to February 17, 1927, that I last saw h[illegible] alive on February 17, 1927, and that death occurred, on the date stated above, at 8:30 P m.

The CAUSE OF DEATH* was as follows:

Chronic & Acute Alcoholism

(duration) ? yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) .....yrs. .....mos. 2 ds.

18 Where was disease contracted

If not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? general & Laboratory

(Signed) R. Hooper Lintt, M. D.

2-6, 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery Date of Burial 2/21-1927

20 UNDERTAKER Chas P. Grace & Son ADDRESS 1818 Druid Hill Ave

Spec.—1-12-23—M&T—500 Bks.

19160 HEALTH DEPARTMENT—CITY OF BALTIMORE E 19160

# CERTIFICATE OF DEATH.

1-PLACE OF DEATH new Park Heights REGISTERED NO.

CITY OF BALTIMORE: (No. Bancroft Road ST., 2 (WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emily Nattans Herbert

(a) RESIDENCE NO. New York. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Nicholas Herbert

6 DATE OF BIRTH (month, day, and year) Dec. 3, 1876

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 50 | 1 | 18 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) New York N.Y.
(State or country)

PARENTS

10 NAME OF FATHER Arthur Nattans

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs. Morton Decatt
(Address) Bancroft Rd.

15 FILED 8 1927, 19 C. HAWSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/18/ 1927.

17 I HEREBY CERTIFY, That I attended deceased from Feb. 16, 1927, to Feb. 18, 1927, that I last saw h[illegible] alive on Feb. 18, 1927, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) 3 yrs. mos ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Samuel Walman, M. D.

2-18-1927 (Address) 2444 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Brooklyn, N. Y. | 2/18/ 1927 |
| 20 UNDERTAKER David Landheim | ADDRESS 1128 W. Mt. Royal Ave |

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19161

## CERTIFICATE OF DEATH.

19-27

197 E 19161

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 104 N. Gilmor St St., _____ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William E. Moore

(a) RESIDENCE NO. 104 N. Gilmor Street St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Col'd. | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of --

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 40 Years | -- | -- | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer) --

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Unknown

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown

(State or country)

14 Informant --

(Address)

Filed ... 19 ...

Per _____ Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 31 st, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun shot wound of brain and abdomen. Homorrhage.

oh once

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) --

(duration) ...yrs. ...mos. ...ds.

(Signed) Thos. B. Norton M. D.

(Coroner)

Feb 16 1927 (Address) 1 Cedar St Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY Date of Burial FEB 18 1927

20 UNDERTAKER Commissioner Health. (ADDRESS)

Feb 8 1927 C. HAMPSON JONES, M. D.

THE MORGUE.

Spec.—7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19162

## CERTIFICATE OF DEATH

38 E 19162

1-PLACE OF DEATH

REGISTERED NO. 18-29

City of BALTIMORE: (No. University Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman Alexander Hopewell

(a) RESIDENCE NO. 774 Redwood St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Black | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1907

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 20 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer O.D.

(b) General nature of industry, business, or establishment in which employed (or employer) Livery Stable

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town) —

(State or country) Md

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) Unknown

(State or country) Md

14 Informant Elizabeth Newman

(Address) 744 Redwood St.

15 Filed 8 1927 C. HAMPSON JONES, M. D. Registrar

Per RRH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/16 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 7, 1927, to Feb. 16, 1927, that I last saw him alive on Feb. 16, 1927, and that death occurred, on the date stated above, at 7 1/2 a. m.

The CAUSE OF DEATH* was as follows:

Cerebrospinal Lues

General arteriosclerosis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Gangrene of left foot

(duration) ..... yrs. 1 1/2 mos. ..... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) E K Mueller, M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Mt Auburn Cem | Feb 18 1927 |
| 20 UNDERTAKER | ADDRESS |
| David Carlson | 916 Eu Ave |

Very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 19163

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19163

## CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

City of BALTIMORE: (No.) Baltimore City Hospitals St. (H. B.) 16-22 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Johnson

(a) RESIDENCE NO. 820 N. Vincent st. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE: Years 31 | Months 30 | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town)

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Emanuel Johnson

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Maryland

12 MAIDEN NAME OF MOTHER: Eliza Roberts

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Maryland

14 Informant: Hospital Records

(Address)

15 FEB 18 1927 C. HAMPSON JONES, M. D.

Per RCB Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

February 17, 1927

17

I HEREBY CERTIFY, That I attended deceased from January 21, 19 27 to February 17, 19 27,

that I last saw him alive on February 17, 19 27,

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis; tuberculous peritonitis; tuberculous cystitis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) W. H. Collins, M. D.

2-17-27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

Date of Burial: Feb 19 19 27

20 UNDERTAKER: Wm A Carton

ADDRESS: 916 Pa ave

Spec.—1-12-23—M&T—500 Blks.

~~208~~ 247
~~E~~ 19164

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 19164

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. George Rau

(a) RESIDENCE NO. Tusca Loosa - Ala. ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 27 1873

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min |
|---|---|---|---|---|
| | 53 | 11 | 22 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... Physician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Swiss -

PARENTS

10 NAME OF FATHER Ernest Rau

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Remeau

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Swiss

14 Informant Records - (Address) JOHNS HOPKINS HOSPITAL

15 Filed 8 1927 C. HAMPSON JONES, M. D., Registrar

Par RRR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 15, 1927, to Feb 18, 1927, that I last saw him alive on Feb 18, 1927 and that death occurred, on the date stated above, at 2 20a. m.

The CAUSE OF DEATH* was as follows:

Brain Tumor
glioma, malignant.

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 2/16/27

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) George E. Jenney, M. D.

2/18/27 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Tuscaloosa, Alabama — DATE OF BURIAL: Feb. 19 27

20 UNDERTAKER: John O. Mitchell — ADDRESS: 1900 Eutaw Place

Spec.–7-17-26–A Co.–200 Bks.

E 19165

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

90 E 19165

1-PLACE OF DEATH

REGISTERED NO. 24-33

City of BALTIMORE: (No. 1316 William St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha J. Hardesty.

(a) RESIDENCE NO. 1316 William St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. — mos. — ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | white | widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Hardesty

6 DATE OF BIRTH (month, day, and year) Sept 30 - 1845

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..hrs. or ..min.. |
|---|---|---|---|---|
| | 81 | 4 | 18 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Calvert Co (State or country) Md

PARENTS

10 NAME OF FATHER James Poore

11 BIRTHPLACE OF FATHER (City or town) (State or country) Calvert Co Md.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs. Martha Gibson (Address) 1316 William St

15 Filed FEB 8 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 Feb. 18. 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 1 - 1926 to Feb 18 - 1927, that I last saw h.x alive on Feb 16 - 1927, and that death occurred, on the date stated above, at 2. 2 m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis.

(duration) since yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) G. P. Burton, M. D.

2/18. 1927 (Address) 801 E Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL W. Harmons Calvert Co Md

Date of Burial Feb 20 1927

20 UNDERTAKER Margaret G. Flynn

ADDRESS 1422 Light St

Very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 19166

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

129 E·19166

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 769 St Peter St. 21-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah F. Poulton

(a) RESIDENCE NO. 769 St. Peter St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. mos. da. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. da.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John R.

6 DATE OF BIRTH (month, day, and year): Dec. 30 1859

7 AGE: Years 67 Months 2 Days 17. IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Balto

(State or country)

PARENTS

10 NAME OF FATHER John P. Smyth

11 BIRTHPLACE OF FATHER (City or town): Germany

(State or country)

12 MAIDEN NAME OF MOTHER Rachel Cramer

13 BIRTHPLACE OF MOTHER (city or town): Md

(State or country)

14 Informant Mrs. Amelia Fowler

(Address) 769 St. Peter St

15 Filed FEB 8 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 17 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1 1926 to Feb 17 1927

that I last saw h alive on Feb 16 1927

and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthma

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Chr Int Nephr

(duration) yrs. 6 mos. da.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) John Ellsworth Kirby M. D.

, 19 (Address) 11 N Wilson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Feb 19 1927 — Date of Burial

20 UNDERTAKER: W. M. Cahoon — ADDRESS: 2 E. Pratt

Very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 19167 HEALTH DEPARTMENT—CITY OF BALTIMORE E 19167

CERTIFICATE OF DEATH.

101-08

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 23 N. Fulton Ave.. (St.) 14-27 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Fisher

(a) RESIDENCE NO. 23 N. Fulton Ave.. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 24, 1879

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 48 | | 23 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work... None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Zacharias Fisher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Senger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mrs. Fischer 23 N. Fulton Ave

15 1927 C. HAMPSON JONES, M. D. Registrar Per RHB

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 16, 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 6th., 1927, to Feb. 16th., 1927, that I last saw h alive on Feb. 16th., 1927, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pneumonia (lobar)

Chronic Endocarditis 2 Yrs.?

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw. Kuelcluss M. D.

, 19 (Address) 24 W Fulton

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer DATE OF BURIAL Feb 19 1927

20 UNDERTAKER Harry H. Witzke ADDRESS 1534 W. Lombard

Spec.—1-12-23—M&T—500 Blks.

E 19168

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19168

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital ST. 16-22 WARD)

REGISTERED NO. 8

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Hull

(a) RESIDENCE NO. 926 N Gilmor St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Colored | Married |

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Jesse L. Hull

6 DATE OF BIRTH (month, day, and year) June 14, 1900

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 26 | 8 | 3 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Aulton

11 BIRTHPLACE OF FATHER (city or town) (State or country) A.A. Co. Md

12 MAIDEN NAME OF MOTHER Mollie Thorton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard Co Md

14 Informant Marie Hull

(Address) 926 N Gilmor St.

15 8 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 17 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1927, to Feb 17, 1927, that I last saw h~~er~~ alive on Feb. 17, 1927, and that death occurred, on the date stated above, at 5.25 a. m.

The CAUSE OF DEATH* was as follows:

Puerperal Septicemia

(duration) yrs. appx mos 10 ds.

CONTRIBUTORY (Secondary) Scarlet Fever

(duration) yrs. mos. 17 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Date of

Was there an autopsy? yes

What test confirmed diagnosis? clinical + autopsy

(Signed) Myron G. Hull, M. D.

2/18. 1927 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hollingsworth Meth Co Md.

DATE OF BURIAL Feb 19 1927

20 UNDERTAKER Sam'l W. Close & Son

ADDRESS 1100 Madison

Spec—12-23-21—E.B.R.S.—400 Bks.

E 19169

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19169

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

City of BALTIMORE: (No. Lombard & Greene St. 15-23 162 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Jackson

(a) Residence No. 1384 N. Stockton St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Black

5-Single, Married, Widowed, or Divorced, (write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 2-16-27

7-AGE: ....yrs. ....mos. ....ds. If LESS than 1 day, ....hrs. or 5 min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Baby
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Maryland

PARENTS

10-NAME OF FATHER. Alfred Jackson

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Elvira Briscoe

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

14-
(Informant) Alfred Jackson
(Address) 1384 N. Stockton

15-
Filed 8 1927
C. HAMPSON JONES, M. D.
192
Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 2-16-27

17- I HEREBY CERTIFY, That I attended deceased from 2-16 19 27 to 2-16 19 27
that I last saw h CV alive on 2-16 19 27
and that death occurred, on the date stated above, at 3 33 m.
The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Partial Premature separation

(Duration) yrs. mos. ds.

If Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Cora F. Dodge M. D.
2 17 19 27 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

| 19-PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL. |
|---|---|
| W Laurel | Feb 19 1927 |
| 20-UNDERTAKER. | ADDRESS |
| Sam'l M Gravina | 1400 Madison |

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19170 E 19170

## CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospital St. 15-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Addison Jefferson

(a) RESIDENCE NO. 1325 Wholesaat St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | Col | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1862

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 65 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver & Teamster

(b) General nature of indnsiry, business, or establishment in which employed (or employer) Dr

(c) Name of employer

9 BIRTHPLACE (city or town) Va

(State or country)

PARENTS

10 NAME OF FATHER Ned Jefferson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Kezia

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Hospital Record,

(Address) Balto City Hospital

15 Filed 8 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Feb. 15, 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan. 14, 1927, to Feb. 15, 1927

that I last saw h[illegible] alive on Feb. 15, 1927

and that death occurred, on the date stated above, at 5-30 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerotic Cardiovascular Disease — Chronic Nephritis, Benign Obstructive Prostatic Hypertrophy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of Feb. 13, 1927

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) W. Barnard, M. D.

, 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cemetery. Date of Burial Feb 19 1927

20 UNDERTAKER Mrs Sad H. Dennis ADDRESS 1303 Pleasant St

Asst T. E. Nelson

Spec.—5-19-13—M. & T.—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19171

## CERTIFICATE OF DEATH.

101-901

E 19171

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1606 Calhoun ST. 15-21 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lorraine C Chase

(Residence in Baltimore: No. 1606 Calhoun St.; yrs. 5 mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Single

6-DATE OF BIRTH ..... (Month) ..... (Day) ..... (Year)

7-AGE, 5 Mo 4 ..... yrs. ..... mos. ..... ds.

If LESS than 1 day ..... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, James Chase

11-BIRTHPLACE OF FATHER (State or Country) Charles Co Md

12-MAIDEN NAME OF MOTHER Mary A Smith

13-BIRTHPLACE OF MOTHER (State or Country), St Mary's Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Chase

(Address) 1606 Calhoun St.,

15-

Filed ..... C. HEMPSON JONES, M. D. Registrar.

FEB 8 1927 By RKH

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 17, 1927 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 2-16 1927 to 2-17 1927 that I saw her alive on 2-17 1927 and that death occurred, on the date stated above, at 1210 PM

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

..... (Duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Bronchitis

..... (Duration) ..... yrs. ..... mos. 4 ds.

(Signed) ..... M. D.

2-18-, 1927 (Address) 1618 Calhoun

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cemetery — DATE OF BURIAL, Feby 19, 1927

20-UNDERTAKER Wm Jas N. Dennis & Co T. C. Kelam — ADDRESS 1303 Pleasant St

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19172

## CERTIFICATE OF DEATH.

101-001

E 19172

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2204 Penna Ave. St. 14-54 Ward)

2-FULL NAME William H. Moten

(a) RESIDENCE NO. 2204 Penna Ave. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| male | Colored | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah E. Moten

6 DATE OF BIRTH (month, day, and year) Sept. 15, 1889

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 37 | 38 | 5 | 2 |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer) Trucking Co

(c) Name of employer

9 BIRTHPLACE (city or town) _____ Feb 19, 1927

(State or country) Va

PARENTS

10 NAME OF FATHER Rev. J. T. Moten

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Va

12 MAIDEN NAME OF MOTHER Jackson

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Auburn

14 Informant Mrs. Sarah E. Moten

(Address) 2204 Penna Ave

15 Filed _____ 19 _____ THOMPSON JONES CO.

By _____ Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 17 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ____ yrs. ____ mos. 5 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) _____ M. D. (Coroner)

Feb 19, 1927 (Address) 2 S Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery. Date of Burial 2/21 1927

20 UNDERTAKER M. D. W. Dennis per. T. E. Nelson. ADDRESS 1303 Presstman St

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19173

## CERTIFICATE OF DEATH.

E 19173

1-PLACE OF DEATH

City of BALTIMORE: (No. Ridgely & Wilson St. Ward 26-6-11 8.)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Teresa Byrd

(a) RESIDENCE NO. Ridgely & Wilson St. Ward 26

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): January 9, 1925.

7 AGE: Years 2 Months Days 18 / 19

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Wm Byrd

11 BIRTHPLACE OF FATHER (city or town)

(State or country) N C

12 MAIDEN NAME OF MOTHER Stella Ann

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Stella Byrd.

(Address) Ridgely & Wilson

15 [illegible] C. HAMPSON JONES, M. D.

Feb 15, 1927 Per DFH Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 7 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) and Chronic Enteritis

(duration) yrs. mos. ds.

(Signed) D. J. Thomas M. D. (Coroner)

Feb 15, 1927 (Address) 2502 Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dr. Peters Burial Feb 19 1927

20 UNDERTAKER: Hamilton

ADDRESS 69 ans

Very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 19174

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 19174

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1404 Bond ST., 14-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Galloway

(a) RESIDENCE No. 1404 Bond ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Colored | Widowed |

5a If married, widowed, or divorced ~~HUSBAND of~~ WIFE of Samuel Galloway

6 DATE OF BIRTH (month, day, and year) June 2. 1844

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 82 | 8 | 15 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Gambrills Md

PARENTS

10 NAME OF FATHER Andrew Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Harriett Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Annie Green

(Address) 1724 W. Fayette St

15 Filed 9 1927 19 Per C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 17. 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan. 9th, 1927, to Feb 17, 1927, that I last saw her alive on Jan 16th, 1927, and that death occurred, on the date stated above, at 4:10 P m.

The CAUSE OF DEATH* was as follows:

Pyaemia Abscess

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Ellis, M. D.

(Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lakelington Md

DATE OF BURIAL Feb 19 1927

20 UNDERTAKER David Easton

ADDRESS 716 Eutaw

Spec.—1-10-21—M&T—1500 Bks.

(Omes)

E 19175

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19175

## CERTIFICATE OF DEATH.

11-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2 Calvert St. (St.) Brooklyn (Ward) ~~Balto~~ 15

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Omes

(a) RESIDENCE NO. 2 Calvert St (St.) Brooklyn (Ward) Balto

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): June 18th, 1926

7 AGE — Years: — Months: 8 Days: — If LESS than 1 day, — hrs. or — min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Brooklyn Balto Md

PARENTS

10 NAME OF FATHER: Thomas H. Omes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Patapsco Hill A. A. Co. Md

12 MAIDEN NAME OF MOTHER: Laura V. Fairley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Essex County Virginia

14 Informant: Thomas H. Omes

(Address) 2 Calvert St Brooklyn Balto Md

15 9 1927 C. HAMPSON JONES, M. D. Registrar

Per [illegible]

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 18th, 1927

17 I ~~HEREBY~~ CERTIFY, That I attended deceased from Feb 11th, 1927, to Feb 18th, 1927, that I last saw him alive on Feb 15th, 1927, and that death occurred, on the date stated above, at 12 50 a m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) — yrs. — mos. 8 ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) — yrs. — mos. 5 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) Thos. Kleibel M.D.

(Address) 1324 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Furnace Brand — DATE OF BURIAL: 2-20-27

20 UNDERTAKER: John H. Tradum — ADDRESS: 1027 Hanover

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19176

## CERTIFICATE OF DEATH.

129 E 19176

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1513 W Lombard St., ST., 19-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Bemisderfer,

(a) RESIDENCE NO. 1513 W Lombard St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose L. (nee Workman)

6 DATE OF BIRTH (month, day, and year) Oct. 12, 1869

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 57 | 4 | 3 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Glass Business.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio.

PARENTS

10 NAME OF FATHER S. P. Bemisderfer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pluna.

12 MAIDEN NAME OF MOTHER Siglar,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Rose Bemisderfer. (Address) 1513 W Lombard St.

15 9 1927 19 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 16 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 8, 1927, to Feb 16, 1927, that I last saw him alive on Feb 16, 1927, and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) yrs. 11 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinalysis

(Signed) [illegible], M. D.

2/19, 1927 (Address) 541 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 2/19 1927

20 UNDERTAKER Harry K Wetzler

ADDRESS 1531 W. Lombard St

Spec. 1-10 21 M&T 1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19177

## CERTIFICATE OF DEATH.

31

E 19177

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1726 Hanover ST., 23-32 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie L. Holloway

(a) RESIDENCE NO. 1726 Hanover ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James E Holloway

6 DATE OF BIRTH (month, day, and year) 1870

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs or ... min. |
|---|---|---|---|---|
| | 57 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John White

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant James E. Holloway (Address) 1726 Hanover St.

15 9 1927 C. HAMPSON JONES, M. D. Registrar

Per RFB

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 16 1927

17 I HEREBY CERTIFY, That I attended deceased from June 22, 1922 to Feb 16, 1927.

that I last saw h alive on Feb 16, 1927.

and that death occurred, on the date stated above, at 8.20 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. B. Campbell, M. D.

Feb 17, 1927 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL 2-19-1927

20 UNDERTAKER Robt. Brooks & Son

ADDRESS Calhoun Hollins Sts

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19178

E 19178

## CERTIFICATE OF DEATH

89

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 340 Hanover St., 27 Ward) 27-55

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm H. Benson

(a) RESIDENCE NO. 340 Hanover St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4½ yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Florence A Benson

6 DATE OF BIRTH (month, day, and year): Feby 19 – 1857

7 AGE: 69 Years 11 Months 27 Days. IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Dressing

(b) General nature of Industry, business, or establishment in which employed (or employer): 086

(c) Name of employer

9 BIRTHPLACE (city or town): Balto Co Md

(State or country)

PARENTS

10 NAME OF FATHER: John Benson

11 BIRTHPLACE OF FATHER (City or town): Balto Co Md

(State or country)

12 MAIDEN NAME OF MOTHER: Louisa Gill

13 BIRTHPLACE OF MOTHER (City or town): Balto Co Md

(State or country)

14 Informant: Florence A Benson

(Address) 340 Hanover St

15 Filed: C. HAMPSON JONES, M. D. Registrar

19 1927 Per ACH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feby 16 – 27 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 14, 1927, to Feb 16, 1927, that I last saw h[illegible] alive on [illegible] 1927, and that death occurred, on the date stated above, at 1 30 P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Myocardial Degeneration

(duration) yrs. 6 mos. ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

2/17. 1927 (Address) 3401 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Louis Ridgely Cemetery

Date of Burial: Feby 19 1927

20 UNDERTAKER: Robt Penner Inc

ADDRESS: [illegible] Balto.

Very important. See instructions on back of certificates.

Spec. -7-17-26—A Co.—20ℓ Bks.

E-19179

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E-19179

## CERTIFICATE OF DEATH

129

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1637 Harley Ave St. 8-45 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank L Ridenour

(a) RESIDENCE NO. 1637 Harley Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mabel E Ridenour

6 DATE OF BIRTH (month, day, and year): June 14 1881

7 AGE: 45 Years 8 Months 3 Days 46

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Hagerstown Md

PARENTS

10 NAME OF FATHER James Ridenour

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Dont Know

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (City or town)

(State or country) Dont Know

14 Informant Mabel E Ridenour

(Address) 1637 Harley Ave

15 Filed 9 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 17 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 27 1927 to Feb 17 1927, that I last saw him alive on Feb 15 1927, and that death occurred, on the date stated above, at 11.30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

2 hours

(duration) yrs. mos. dy.

CONTRIBUTORY (Secondary) Chronic syphilis - Hypertension

(duration) yrs. mos. 22 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? None Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) George Abner Bowden M. D.

Feb. 1927 (Address) 1517 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ballo Cemetery — Date of Burial: Feb 21 1927

20 UNDERTAKER: Robt J Turner — ADDRESS: 1532 Broadway

Very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

Forquignon.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19180

## CERTIFICATE OF DEATH.

E 19180

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Cassvill Hospital ST. WARD)

2-FULL NAME Wm Forquignon

(a) RESIDENCE NO. Unknown - from boat Steamship Atlantic Ports ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | white | ? |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1877

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | about 50 | yrs | | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cook. ?
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

Filed 19 1927 C. HAMPSON JONES, M. D. 192 Registrar

Per THE MORGUE

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 8 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Struck by Opinion

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) (Coroner) M. D.

Feb. 18. 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY

DATE OF BURIAL FEB 18 1927

20 UNDERTAKER Commissioner Health

ADDRESS

Per Wm E Worrall

HOW IS very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19181 1476 E 19181

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 1-2 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Hoerner

(a) RESIDENCE NO. 904 S. Decker St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | white | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ernst Hoerner

6 DATE OF BIRTH (month, day, and year) Jan 2/1888

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 39 | 1 | 16 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md

PARENTS

10 NAME OF FATHER August Deares

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Rosina Drauner

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Ernst Hoerner

(Address) 904 Decker Ave

Filed 2 1927 C. HAMPSON JONES, M. D.

Rec'd Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 16/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Purulent Meningitis
Puerpal Infection of uterus
Thrombosis of uterine & ovarian veins.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) (Autopsy at Hopkins)

(duration) ....yrs. ....mos. ....ds.

(Signed) J. M. Bolen M. D.

(Coroner)

2/19/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Pauls (Swartzes) Date of Burial 2/21 1927

20 UNDERTAKER Louis Heemann ADDRESS 32 S Bway

Very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 19182 HEALTH DEPARTMENT—CITY OF BALTIMORE E 19182

CERTIFICATE OF DEATH. 100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2 E. Hamilton Ave., Hamilton ST. 27-43 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles G. Tames

(a) RESIDENCE NO. 2 E. Hamilton Ave. Hamilton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah J. Tames

6 DATE OF BIRTH (month, day, and year) March 12, 1860.

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 66 | 11 | 5 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co., Maryland

PARENTS

10 NAME OF FATHER John H. Tames.

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine Gellner

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Germany

14 Informant Mrs. Sarah J. Tames

(Address) 2 E. Hamilton Ave. Hamilton

15 9 1927 C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 17, 1927.

17 I HEREBY CERTIFY, That I attended deceased from Feb. 14th, 1927. to Feb 17th, 1927.

that I last saw h in alive on Feb 17th, 1927.

and that death occurred, on the date stated above, at 1.40 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia (over)

(duration) — yrs. — mos 3 ds.

CONTRIBUTORY (Secondary) Infected Tonsil

(duration) — yrs. — mos. 10 ds.

18 Where was disease contracted if not at place of death? No 2 East Hamilton Ave

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Yes

(Signed) George L. Vogler, M. D.

, 19 (Address) No 2 East Hamilton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Perkwood Cemetery

DATE OF BURIAL Feb. 20, 1927.

20 UNDERTAKER Frederick Laggahn & Son

ADDRESS Fullerton

Per Fredk Laggahn

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19183

## CERTIFICATE OF DEATH.

159-002

E 19183

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 15 Anthony Ave 26-41 St., Ward)

2-FULL NAME John Trageser

(a) RESIDENCE NO. 15 Anthony Ave St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 16/27

| 7 AGE | Years | Months | Days | IF LESS than 1 day...hrs. or.....min. |
|---|---|---|---|---|
| | | | | 15 |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Martin Trageser

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Mary Steadman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto., Md.

14 Informant Martin Trageser

(Address) 15 Anthony Ave

15 Filed 9 1927 C. HAMPSON JONES, M. D. Registrar

By R.S.B.

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 Feb 16/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Probably Congental Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. Hampson Jones M. D.
(Coroner)

2/19/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Harley Redeemer Cemetery Date of Burial Feb 19 1927

20 UNDERTAKER Henry Heuck & Sons ADDRESS 1301 E Eager St

Very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 19184

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19184

## CERTIFICATE OF DEATH.

91-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mt Hope Retreat (ST.) 28-63 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister Mary Agnes Reid

(a) RESIDENCE NO. Mt Hope Retreat ST., WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. — mos. — ds. How long in U. S., if of foreign birth? 80 yrs. 7 mos. 17 ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 1, 1846

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs or ... min. |
|---|---|---|---|---|
| | 80 | 7 | 17 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sister of Charity

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Thomas Reid

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sophia Beckham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington D.C.

14 Informant Mt Hope Retreat (Address) City

15 FEB 9 1927 19 C. HAMPSON JONES, M. D. Per ____ Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1926, to Feb 18, 1927, that I last saw her alive on Feb 17, 1927, and that death occurred, on the date stated above, at 4.07 P m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) 10 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) — yrs. 2 mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) C. B. Eudor, M. D.

2-18 1927 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Hope Cemetery

DATE OF BURIAL Feb 20 1927

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor)

ADDRESS 103 W. NORTH AVE.

Spec.—1-12-23—M&T—500 Blks.

Clayton

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19185

E 19185

## CERTIFICATE OF DEATH.

27-53 129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6 Beechdale Road ST. WARD)

2-FULL NAME Mabelle Josephine Clayton

(a) RESIDENCE NO. 6 Beechdale Road ST., WARD Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 60 yrs. 9 mos. 16 ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fred.L.Clayton

6 DATE OF BIRTH (month, day, and year) May-2-1858

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs or ....min. |
|---|---|---|---|---|
| | 68 | 9 | 16 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Ilsboro
(State or country) Maine

PARENTS

10 NAME OF FATHER L.P.Gilley

11 BIRTHPLACE OF FATHER (city or town) ??
(State or country) Maine

12 MAIDEN NAME OF MOTHER S.J.Sprague

13 BIRTHPLACE OF MOTHER (city or town) ??
(State or country) Maine

14 Informant Mrs. William C.Reid
(Address) 6 Beechdale Road

15 FEB 9 1927, 19 C. HAMPSON JONES, M. D.
By ——— Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 18 1927.

17 I HEREBY CERTIFY, That I attended deceased from Feb. 13, 1927, to Feb. 18, 1927, that I last saw her alive on Feb. 17, 1927, and that death occurred, on the date stated above, at 2-45 a. m.

The CAUSE OF DEATH* was as follows:

Uremic Coma

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 2+ yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Examination of urine

(Signed) M. Gibson Porter, M. D.

2/18, 1927. (Address) 422 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Feb-13-27 19

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOOLLEN, Successor)

ADDRESS 103 W. NORTH AVE.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19186

## CERTIFICATE OF DEATH.

90 E 19186

REGISTERED NO._____

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St., 325 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Smith

(a) RESIDENCE NO. 812 E Pratt St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | ? |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1849

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 78 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) O'K D

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant

(Address) Records

BALTIMORE CITY HOSPITALS

FEB 19 1927

C. HAMPSON JONES, M. D.

Registrar

9 1927 660 Per R.K.W.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 17 1927

17

I HEREBY CERTIFY, That I attended deceased from August 20, 1925, to February 17, 1927, that I last saw him alive on February 16, 1927, and that death occurred, on the date stated above, at 5.45 A. m.

The CAUSE OF DEATH* was as follows:

Senility

Hypostasis

Chronic Myocarditis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? general laboratory

(Signed) G. Hooper Smith M. D.

Feb 18 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

ADDRESS

20 UNDERTAKER Commissioner Health.

JOHNS HOPKINS HOSPITAL FEB 19 1927

Very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

19187

# HEALTH DEPARTMENT—CITY OF BALTIMORE

19187

## CERTIFICATE OF DEATH.

101-8

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 751 Dolphin ST. 17-24 (WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Young

(a) RESIDENCE NO. 751 Dolphin ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colord | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maude Young

6 DATE OF BIRTH (month, day, and year) — 1885

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ... min. |
|---|---|---|---|---|
| | 42 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur 123

(b) General nature of industry, business, or establishment in which employed (or employer) Private

(c) Name of employer Alexander C. Weiler

9 BIRTHPLACE (city or town) Baltimore City (State or country) Md

PARENTS

10 NAME OF FATHER Absolom Young

11 BIRTHPLACE OF FATHER (city or town) Va (State or country)

12 MAIDEN NAME OF MOTHER Rebecca Young

13 BIRTHPLACE OF MOTHER (city or town) Va (State or country)

14 Informant (Address) John A. Young 751 Dolphin St.

15 Filed 2 9 1927 C. HAMPSON JONES, M. D. Registrar Per ABH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 17th 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 15th 1927 to Feb 17th 1927.

that I last saw him alive on Feb 17th 1927

and that death occurred, on the date stated above, at 7.35 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Jos. Sam'l Fell M. D.

2/18 1927 (Address) 713 Linwood Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Mt. Auburn Cem. | 2/19 27 |

20 UNDERTAKER Samuel S. Hensley ADDRESS 678 W. Balto St.

FROM is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19188

E 19188

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Provident Hospital 10-14 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Kilgore

(a) RESIDENCE NO. 832 Harford Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | C | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Beulah Kilgore

6 DATE OF BIRTH (month, day, and year) Jan. 10, 1896

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min.. |
|---|---|---|---|---|
| | 30 | 2 | 5 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer, [illegible]

(b) General nature of industry, business, or establishment in which employed (or employer) General

(c) Name of employer refectory Co

9 BIRTHPLACE (city or town) Greenville S.C.

(State or country)

PARENTS

10 NAME OF FATHER Jerry Kilgore

11 BIRTHPLACE OF FATHER (City or town) Laurence S.C.

(State or country)

12 MAIDEN NAME OF MOTHER Mary Lewis

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Laurence S.C.

14 Informant Beulah Kilgore

(Address) 832 Harford Ave

15 9 1927 C. HAMPSON JONES, M. D. Registrar

Per R.K.S.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 15 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 8, 1927, to Feb. 15, 1927, that I last saw h[illegible] alive on Feb. 15, 1927, and that death occurred, on the date stated above, at 6 12 P m.

The CAUSE OF DEATH* was as follows: Pulmonary Edema.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) yrs. mos. 14-15 ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab findings

(Signed) John W. Kaiser, M. D.

. 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Mt Calvary Cemetery | 2/19/27 |
| 20 UNDERTAKER Mrs. R.A. Elliott | ADDRESS 1725 Edmondson Ave |

very important. See instructions on back of certificates.

Spec—1-10-21—M&T—1500 Bks.

Jones

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19189 E 19189

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 208 N. Stricker ST. 19-27 74 201 WARD)

2-FULL NAME Robert Jones

(a) RESIDENCE NO. 208 N. Stricker ST., ..... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | Widowed |

5a If married, widowed, or divorced
HUSBAND of
~~(or) WIFE of~~ Unknown

6 DATE OF BIRTH (month, day, and year) — — 1850

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or ..... min. |
|---|---|---|---|---|
| | 77 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of Industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mary Jones

(Address) 208 N Stricker St

Filed 9-1927 19 C. HAMPSON JONES, M. D. Registrar

By ACH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 17. 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 19 27 to Feb 17. 19 27.

that I last saw h alive on Feb. 16th 19 27.

and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Progressive Cardiac Hypertrophy

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Old age

..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R Lee Ellis, M. D.

2/5, 1927 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| New Cathedral | 2/4/27 |
| 20 UNDERTAKER Mrs. R.G. Elliott | ADDRESS 925 Ashland Ave. |

Spec.—1-12-23—M&T—500 Blks.

1985-2
E 19190

# HEALTH DEPARTMENT—CITY OF BALTIMORE E 19190

## CERTIFICATE OF DEATH.

146

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL St., 7-13 Ward)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Borbsman

(a) RESIDENCE NO. 1631 N-Wolfe St St. WARD A-2
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~or WIFE of~~ Henry Borbsman

6 DATE OF BIRTH (month, day, and year) January 1895

7 AGE: Years 28 | Months | Days | If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): South Car —

PARENTS

10 NAME OF FATHER: Benson Glyn

11 BIRTHPLACE OF FATHER (city or town) (State or country): S. Car

12 MAIDEN NAME OF MOTHER: Georgia Wells

13 BIRTHPLACE OF MOTHER (city or town) (State or country): S. Car -

14 Informant: Records —
(Address) JOHNS HOPKINS HOSPITAL

Filed 9 1927 C. HAMPSON JONES, M. D. Registrar
By CFH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 2, 1927, to Feb 18, 1927, that I last saw her alive on Feb 18, 1927 and that death occurred, on the date stated above, at 12 30 a. m.

The CAUSE OF DEATH* was as follows:

Septicemia, Thrombophlebitis, puerperal or metritis, after abortion on Jan. 18, 1927. (over)

(duration) — yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary) Endometritis. Oophoritis ?

(duration) — yrs. mos. ? ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of Feb 14, 1927

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy & Operation.

(Signed) Raymond Kaufman, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel A. C.

DATE OF BURIAL: 2/20/27

20 UNDERTAKER: Mrs. R. A. Elliott

ADDRESS: 1725 Eutaw

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19191 185 E 19191

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1207 Oak Heart St. 16-68 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ruth Elizabeth Stewart

(a) RESIDENCE NO 1207 Oak Heart St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 24 mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | W | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 24/27

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | | | 24 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ooo

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country)

PARENTS

10 NAME OF FATHER Howard Stewart

11 BIRTHPLACE OF FATHER (city or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Ida R Barden

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Howard Stewart

(Address) 1207 Oak Heart St

Filed 9-1927 C. HAMPSON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Coroner, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Acc Fall.

Central Concussion

(Duration) yrs. mos. 1 hrs.

CONTRIBUTORY (Secondary) Shock.

(Duration) yrs. mos. 1 da.

Feb 19 27 (Signed) G C Yates M. D.

(Coroner)

(Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Date of Burial Feb 19 1927

20 UNDERTAKER E L Roy Stiffler ADDRESS 1252 North Ave

Very important. See instructions on back of certificate.

Spec.—12-23-21—E.B.R.S.—400 Bks.

E 19192 HEALTH DEPARTMENT—CITY OF BALTIMORE E 19192

CERTIFICATE OF DEATH.

10-15 90

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 921 Forest St., 10-15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia Logan

(a) Residence No. 921 Forest St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, ~~or Divorced~~ (Write the word.) Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Alexander Logan

6-DATE OF BIRTH (month, day and year) 11/5/71 or 20

7-AGE 56 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town). (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Anna Dent.

13-BIRTHPLACE OF MOTHER (city or town). (State or Country), Va

14- (Informant) Mrs. Harriet R. Brooks

(Address) 921 Forest St.

15-

16- 9 1927 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 17 '27

17- I HEREBY CERTIFY, That I attended deceased from Jan 2 1927 to Feb 17 1927.

that I last saw her alive on Feb 13 1927.

and that death occurred, on the date stated above, at 5:45 P. M.

The CAUSE OF DEATH* was as follows:

Myocarditis.

(Duration) yrs. mos. 22 ds

CONTRIBUTORY (Secondary)

Grippe (Duration) yrs. mos. 2 ds

18-Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Personal observation

(Signed) Wm Leonard Brooks, M. D.

, 19 (Address) 1900 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Olivet Cemetery

DATE OF BURIAL. 2/21 1927

20-UNDERTAKER. Chas H Bailey

ADDRESS 1424 Jefferson St

Spec.—1-10-21—M&T—1500 Blks.

E 19193

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19193

## CERTIFICATE OF DEATH.

+ 57

1-PLACE OF DEATH Maryland General Hosp. 11-24

CITY OF BALTIMORE: (NO. ..... ST. WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas L. Abell

(a) RESIDENCE NO. 137 Newburg Ave, Catonsville, Md. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. 20 da. How long in U. S., if of foreign birth? yrs. mos. da.

If non-resident give city or town and State

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Josephine Abell.

6 DATE OF BIRTH (month, day, and year): Oct 8 1838

7 AGE — Years: 68 — Months: 4 — Days: 9 — If LESS than 1 day, .... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Traveling Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): St. Marys Co. Md.

PARENTS

10 NAME OF FATHER: Thomas Abell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Eleanor Armitage

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Mr. Edith Baker 137 Newburg Ave.

15 9 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 28 .1927. to Feb. 18 .1927, that I last saw HIM alive on Feb. 18 .1927, and that death occurred, on the date stated above, at 8:30 A m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 15 yrs. mos. da.

CONTRIBUTORY (Secondary): Diabetic Gangrene

(duration) 2 yrs. mos. da.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes. Date of Feb. 8, 1927

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Jno A Thompson M. D.

.19 (Address) 111 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: Feb 24 1927

20 UNDERTAKER: George J Smith

ADDRESS 1532 Hollins

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19194

## CERTIFICATE OF DEATH.

E 19194

REGISTERED NO. 57

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2411 Orleans St., 6-10 Ward)

2-FULL NAME Sarah Mc. Sweeney

(a) RESIDENCE NO. 2411 Orleans St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred, yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov. 29/1866

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 60 | 2 | 18 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto.

(State or country): Md.

PARENTS

10 NAME OF FATHER: Dennis Mc. Sweeney

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Ireland

12 MAIDEN NAME OF MOTHER: Elizabeth Cambell

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Ireland

14 Informant: Anna M. Silverson

(Address): 2411 Orleans St.

Filed ..... 19 ..... C. HAMPSON JONES, M. D.

Per ..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feby 17 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec. 30, 1926, to Feby 17, 1927, that I last saw her alive on Feby 17, 1927 and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows: Chronic Nephritis Interstitial Nephritis and Diabetes Mellitus

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... ds.

Is Where was disease contracted —

If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Examination

(Signed) Geo. L. Wachter, M. D.

1927 (Address) 2246 E. 39

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cath — Date of Burial Feb 21/27 19

20 UNDERTAKER: Jos J. Sterrenberg ADDRESS 156 Lafayette

Very important. See instructions on back of Certificates.

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19195

## CERTIFICATE OF DEATH.

10 E 19195

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital ST., 10 37 WARD

2-FULL NAME Amanda Bertha Getnear

(a) RESIDENCE NO. 3609 Mt. Pleasant Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. 10 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 20, 1918

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs or ....min. |
|---|---|---|---|---|
| | 8 | 10 | 29 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER August Getnear

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Jennie Elliott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Laurel, Del.

14 Informant Mrs. August Getnear (Address) 3609 Mt. Pleasant Ave

15 Filed 9 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 8 1927, to Feb. 18 1927, that I last saw her alive on Feb. 18 1927 and that death occurred, on the date stated above, at 12 40 P. m.

The CAUSE OF DEATH* was as follows:

Tonsillar - Pharyngeal Diphtheria

(duration) yrs. mos 13 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 6 da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical - Pos. K.L. culture

(Signed) Mynor C. Tull, M. D.

2/19, 1927 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. - Feb 21/27 DATE OF BURIAL 19

20 UNDERTAKER John J. Grimstone ADDRESS 156 Fayette ave.

Cor.—12-9-25—A Co.—200 Bks.

E 19196

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 19196

1-PLACE OF DEATH

City of BALTIMORE: (No. St Joseph Hospital St. 10-14 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Chu Chinn See

(a) RESIDENCE NO. 1211 Greenmount Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | yellow | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chu Park

6 DATE OF BIRTH (month, day, and year) Aug 11/1890

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 36 | 6 | 5 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) China

PARENTS

10 NAME OF FATHER Chin Yee Yie

11 BIRTHPLACE OF FATHER (city or town)

(State or country) China

12 MAIDEN NAME OF MOTHER Yee Shee

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) China

14 Informant Chu Park

(Address) 1211 Greenmount Ave

9-1927 C. HAMPSON JONES, M. D.

Registrar

Per

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 10/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage-Shock

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Placentia Praevia

(duration) yrs. mos. ds.

(Signed) J. H. Price M. D.

(Coroner)

2/13/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Date of Burial Feb 21 1927

20 UNDERTAKER John A. Mitchell ADDRESS 1900 Eutaw Pl.

Very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Virgia A. Gordon

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19197

## CERTIFICATE OF DEATH.

E 19197

1-PLACE OF DEATH 1318 E. Lexington St 128

CITY OF BALTIMORE: (No. 1318 ST. E. Lexington WARD 5-8)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Virginia A Gordon

(a) RESIDENCE No. 1318 E Lexington ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | col. | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wesley Gordon

6 DATE OF BIRTH (month, day, and year) [illegible]

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 39 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Richmond Va

PARENTS

10 NAME OF FATHER William Venus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Richmond Va

12 MAIDEN NAME OF MOTHER Catherine Rich

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Richmond Va

14 Informant Henry Gordon

(Address) 1318 E Lexington st

15 (Date) 2 0 1927 G. HAMPTON JONES, M. D.

Registrar

Ref

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-17 1927

17

I HEREBY CERTIFY, That I attended deceased from 11-22 1926 to 2-17 1927

that I last saw h[illegible] alive on 2-16 1927

and that death occurred, on the date stated above, at 7 45 p. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

Myocarditis

Acute Nephritis (Chronic)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Laboratory

(Signed) W. B. Butler, M. D.

, 19 (Address) 725 N. Carlton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Richmond Cem Va

Sharp Marly

20 UNDERTAKER Mrs R A Elliott

DATE OF BURIAL Feb 20 1927

ADDRESS 1725 Oakland Ave

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19198

E 19198

## CERTIFICATE OF DEATH.

47

1-PLACE OF DEATH

REGISTERED NO. 21-65

CITY OF BALTIMORE: (No.) 61st Ave + Dunsan Lane WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Schaffer

(a) RESIDENCE NO. 61st Ave + Dunsan Lane WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? 34 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of: Schepschil Schaffer

6 DATE OF BIRTH (month, day, and year): Aug. 15, 1867

7 AGE: Years 59 | Months 6 | Days 3 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

637

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Alexander Lapiduth

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Dr. Aaron Schaffer

(Address): 61st Ave + Dunsan Lane

15 [illegible]

B 28 1927

C. HAMPSON JONES, M. D.

Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/18/ 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct. 1924, to Feb. 19, 1927

that I last saw h[illegible] alive on Feb. 18, 1927

and that death occurred, on the date stated above, at 11 45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinomatosis

Metastases from an Excised

Breast Carcinoma (duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam of Breast tumor

(Signed) Samuel Wolman, M. D.

2-19 1927 (Address) 2444 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Hebrew Cem.

DATE OF BURIAL: 2/20/ 1927

20 UNDERTAKER: David Sondheim

ADDRESS: 1120 W. Mt. Royal Ave

READ very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 19199

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19199

## CERTIFICATE OF DEATH.

47

1-PLACE OF DEATH Etna Apts.

CITY OF BALTIMORE: (No. 2421 Lakeview Ave. ST. 13-54 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Blanche Wolfsheimer.

(a) RESIDENCE NO. 2421 Lakeview Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Arthur Wolfsheimer

6 DATE OF BIRTH (month, day, and year) June 18th. 1891.

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs or ... min. |
|---|---|---|---|---|
| | 35 | 8 | 1 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER David Mehlinger.

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Etta Juhn

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Mrs. Etta Mehlinger (Address) 2421 Lakeview Ave

15 Filed FEB 20 1927 19... C. HAMPSON JONES, M. D. Registrar

Per RK

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby. 19th. 1927

17

I HEREBY CERTIFY, That I attended deceased from June 23, 1926, to Feb 19, 1927, that I last saw h[er] alive on Feb 19, 1927, and that death occurred, on the date stated above, at 12 05 1.30 m.

The CAUSE OF DEATH* was as follows:

Carcinoma (metastatic)
Mediastinum (chest)

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Carcinoma Breast

(duration) 2½ yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of Feb 1925

Was there an autopsy? no (Removal of Breast

What test confirmed diagnosis? usual - microscopic

(Signed) Edwin F. Wagner, M. D.

2/19. 1927 (Address) The Esplanade

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Hebrew Cem..

DATE OF BURIAL 2/21/ 1927

20 UNDERTAKER David Londheim

ADDRESS 138-140 W. Mt. Royal Ave

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19200

## CERTIFICATE OF DEATH.

100 001 E 19200

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 911 Granby ST. 3-5 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace Annette Pellegrini

(a) RESIDENCE NO. 911 Granby ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | W | — |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 5 1927

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs or ....min. |
|---|---|---|---|---|
| | | | 14 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Pasquale Pellegrini

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Giovanna Di Bona

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Pasquale Pellegrini
(Address) 911 Granby

15 Filed 2-8 1927 C. HAMPSON JONES, M. D. Registrar
per K.H.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 19 — 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb. 16, 1927, to Feb. 19, 1927.

that I last saw h[illegible] alive on Feb. 19 —, 1927

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Pneumonia - Bronchial

(duration) yrs. mos 4 ds

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Examination

(Signed) R. W. Pinto M. D.

2-17 1927 (Address) 1300 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Holy Redeemer | Feb 20 1927 |
| 20 UNDERTAKER | ADDRESS |
| Randell Duffield & Son | 37 S Amity |

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002 E 19201

E 19201

## CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 432 N. Luzerne ave. 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry E. Oberlander.

(a) RESIDENCE NO. 432 N. Luzerne ave. 7 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. 18 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Oberlander.

6 DATE OF BIRTH (month, day, and year) Jan. 30th 1856

| 7 AGE | Years | Months | Days | IF LESS than 1 day ...hrs. or ...min.. |
|---|---|---|---|---|
| | 70 | | 18 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work C. P. Tel Co.

(b) General nature of industry, business, or establishment in which employed (or employer) Employe.

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER Henry Oberlander.

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Annie

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany.

14 Informant Elizabeth Oberlander

(Address) 432 N. Luzerne ave

15 Filed ..... 19 ..... Registrar

Per .....

FEB 20 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18th 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 15 27 to Feb 18 27.

that I last saw she alive on Feb 17 1927.

and that death occurred, on the date stated above, at 11 15 P m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

Signed Thy Craven, M. D.

(Address) 143 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery. Date of Burial Feb 22nd 1927

20 UNDERTAKER Lilly Zeiler. ADDRESS 4032 Wash. Ave.

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 19202

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

38 E 19202

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1713 Bank St., W. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maud M. Arnold Witmer

(a) RESIDENCE NO. 1713 Bank St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. 17 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late George Witmer

6 DATE OF BIRTH (month, day, and year) May 22nd 1877

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 49 | 8 | 25 17 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work.

(b) General nature of industry, business, or establishment in which employed (or employer) at Home 037

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER Henry Lamm

11 BIRTHPLACE OF FATHER (city or town) (State or country) U.S.

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U.S.

14 Informant Edith Yaeger (Daughter)

(Address) 1713 Bank St.

FEB 20 1927

15 Filed 19 C. HAMPTON JONES, M. D. Registrar

By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 17th 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1925, to Feb 17, 1927, that I last saw h[illegible] alive on Feb 17, 1927, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Aortic Aneurysm

(doration) 3 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) D. F. Herzog M.D. M. D.

2/20, 1927 (Address) 1305 N. Patterson Pk

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery — Date of Burial Feb 20th 1927

20 UNDERTAKER Lilly + Zeiler — ADDRESS 903 N Wolfe St

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19203

## CERTIFICATE OF DEATH.

90 E 19203

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home Hospital St., 16-15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. John T. Hazlitt

(a) RESIDENCE NO. 438 E. Biddle St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 ~~Single, Married,~~ Widowed, or ~~Divorced.~~ (write the word): Widowed

6a If ~~married, widowed, or divorced~~ HUSBAND of ~~(or WIFE of~~

6 DATE OF BIRTH (month, day, and year) April 23rd 1858

7 AGE: Years 68 | Months 1 9 | Days 25 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James Hazlitt

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore

12 MAIDEN NAME OF MOTHER L Sears

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Easton Md

14 Informant Jno Williams

(Address) 705 St Paul St

15 Filed FEB 20 1927 H. HAMPTON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 February 18-1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 17 1927 to Feb 18 1927, that I last saw h~~im~~ alive on Feb 18 1927, and that death occurred, on the date stated above, at 9 45 P.m.

The CAUSE OF DEATH* was as follows:

Myocardial failure -

(duration) .....yrs. .....mos. 2 ds.

CONTRIBUTORY (Secondary) Cardio-renal decompensation

arteriosclerosis

(duration) 1 yrs. .....mos. .....ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No -

What test confirmed diagnosis?

(Signed) Merrywell D. Statham M. D.

2/19, 1927 (Address) Church Home Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem — Date of Burial: Feb 22 1927

20 UNDERTAKER: Henry R Jenkins Sons Co — ADDRESS: Eden & Fairmount Ave

Very Important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19204

## CERTIFICATE OF DEATH.

49 E 19204

REGISTERED NO. 11-15

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hosp. ST. WARD)

2-FULL NAME Frank Gosnell

(a) RESIDENCE NO. 1212 N. Calvert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6yr yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| M | W | Widower |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Frank Gosnell

6 DATE OF BIRTH (month, day, and year) Dec 13, 1854

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 72 | 2 | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Matthew Gosnell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Jay

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna.

14 Informant Frank Gosnell (Address) 1212 Calvert St.

15 Filed B 20 1927 C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 17 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 26, 1927, to Feb 17, 1927, that I last saw h— alive on Feb 15, 1927, and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of prostate -

(duration) 6 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Feb 8-27

Was there an autopsy? No

What test confirmed diagnosis? Cancer of prostate

(Signed) H. O. Price, M. D.

2/19 1927 (Address) Union Mem. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL Feb 21 1927

UNDERTAKER Henry H. Jenkins & Son Co

ADDRESS Edmondson & McCulloh Sts

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19205

## CERTIFICATE OF DEATH.

117

E 19205

1-PLACE OF DEATH Mercy Hospital

REGISTERED NO.

City of BALTIMORE: (No. 27-54 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sr. M. Hedwig Gilbert Weiler

(a) RESIDENCE NO. St. Agnes Mt. Washington 2116.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 18 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic Work.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country): Md

PARENTS

10 NAME OF FATHER: Asa Weiler

11 BIRTHPLACE OF FATHER (city or town): Balto

(State or country)

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): Ireland

(State or country)

14 Informant

(Address): Mercy Hospital

15 Filed ..... 19..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 20 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb. 11, 1927, to Feb. 20, 1927, that I last saw h[illegible] alive on Feb. 20, 1927, and that death occurred, on the date stated above, at 6 20 4 m.

The CAUSE OF DEATH* was as follows: General Peritonitis + Pneu

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of Feb. 15. 27

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. Motta, M. D.

, 19 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. St. Agnes Mt. Washington Date of Burial Feb 23 1927

20 UNDERTAKER: W. J. Jenkins Sons Co

ADDRESS: Oakland & McCulloh

Very Important. See instructions on back of certificate.

20 1927 C. HAMP... R[illegible]

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 19206 — 129 — E 19206

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 2470 Keyworth Ave St. 15-56 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Moses Ehrlenspiel

(a) RESIDENCE NO. 2470 Keyworth Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S. if of foreign birth 30 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clara

6 DATE OF BIRTH (month, day, and year) [illegible]

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min.. |
|---|---|---|---|---|
| | 53 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Paul Ehrlenspiel

11 BIRTHPLACE OF FATHER (City or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Pearl Ehrlenspiel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Clara Ehrlenspiel

(Address) 2470 Keyworth Ave

15 Filed [illegible] 19 [illegible] C. HAMILTON JONES, M. D.

Per [illegible] Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18th 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 1st, 1927, to Feb 18, 1927, that I last saw h[illegible] alive on Feb 18, 1927, and that death occurred, on the date stated above, at 940 p m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) 8 yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) B. Kadri, M. D.

2/19 1927 (Address) 2306 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — Date of Burial 2/20 1927

20 UNDERTAKER Sol Gunsor & Bro — ADDRESS 1127 E Balto St

very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19207

## CERTIFICATE OF DEATH.

69 E 19207

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 114 Aisquith St. 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachel Lazarus

(a) RESIDENCE. No. 114 Aisquith ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. — mos. — ds. How long in U. S., if of foreign birth? 27 yrs. — mos. — ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Female | White | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isaac

6 DATE OF BIRTH (month, day, and year) [illegible]

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 75 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Ezjek Schloss

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Pira Yik.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant M. L. Moss (Address) 2525 Whitelock st.

15 Filed FEB 20 1927 C. HAMILTON JONES, M. D. Registrar By [illegible]

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 20 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 20, 1927, to Feb. 20, 1927, that I last saw h[illegible] alive on 2-20, 1927, and that death occurred, on the date stated above, at 8.30 a. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Samuel Snyder M. D.

2/20, 1927 (Address) 1634 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Hebrew Rosedale | 2/20 1927 |
| UNDERTAKER Sol Levinson & Bro | ADDRESS 11/27 E Balto st |

Spec.—1-12-23—M&T—500 Blks.

E 19208

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

91-102 E 19208

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 311 N Central ave (St.) 5-8 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michial Richmond

(a) RESIDENCE NO. 311 N Central ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? 37 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sadie Richmond

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 73 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Peddler

(b) General nature of industry, business, or establishment in which employed (or employer) Clothing

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1439 E Baltimore St.

15 Filed 2 0 1927, 19 C. HAMPTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/19 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 17, 1927, to Feb 19th, 1927, that I last saw him alive on Feb. 18th, 1927 and that death occurred, on the date stated above, at 2 a m

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Harry H. Rogers M.D.

, 19 (Address) 3700 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rit Cemet

DATE OF BURIAL 2/20 1927

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E Baltimore St

Spec.—1-12-23—M&T—500 Blks.

E 19209

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 19209

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew aged Home ST. 5-8 WARD)

2-FULL NAME Anna Mustin

(a) RESIDENCE No. 115 Aisquith Street ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? 31 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | W | widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Mustin

6 DATE OF BIRTH (month, day, and year) [illegible]

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 85 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Aged

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer do

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Abbed Mesnick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Antown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant L. Silberstein
(Address) Equitable Bldg

15 Filed 2 8 1927 19 C. HARRISON JONES, M. D.
Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/20 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1926, to 2/20, 1927;
that I last saw h[illegible] alive on 2/20, 1927;
and that death occurred, on the date stated above, at 8 a m

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jacob L. Wiener, M. D.

, 19 (Address) 301 S. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Washington D.C. DATE OF BURIAL 2-1 1927

20 UNDERTAKER Jack Levin ADDRESS 1439 E Eas alx

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19210

## CERTIFICATE OF DEATH

101-001

E 19210

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. University Hosp. Street or Ward) 26-39

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clinton Jessop

(a) RESIDENCE NO. Halleland Balto Co. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Mal | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Ruby B. Jessop

6 DATE OF BIRTH (month, day, and year) July 5 - 1858

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|---|
| | 68 | 7 | 14 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Co

(State or country)

PARENTS

10 NAME OF FATHER William Jessop

11 BIRTHPLACE OF FATHER (City or town) Balto. Co

(State or country)

12 MAIDEN NAME OF MOTHER Mary Johnson

13 BIRTHPLACE OF MOTHER (City or town) Balto Co

(State or country)

14 Informant Mrs Ruby Jessop

(Address) Halleland Md

15 Filed FEB 20 1927 C. HAMPSON JONES, M. D. Registrar

Per RK

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 13, 1927, to Feb 14, 1927, that I last saw him alive on Feb 14, 1927, and that death occurred, on the date stated above, at 12 20 A.m.

The CAUSE OF DEATH* was as follows:

Emphysema

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of Feb 15, 1927

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) Chas Wm Eastwood, M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Halleland Md Date of Burial Feb 25 27

20 UNDERTAKER W. C. Brooks ADDRESS Sparks Md.

very important. See instructions on back of certificates.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

59-002 V

E 19211

## CERTIFICATE OF DEATH.

E 19211 Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2008 Monmonier Court St. 7-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marian Kaliszak

(Residence in Baltimore: No. 2008 Monmonier court St.; yrs., 5/6 mos.....ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

| 3-SEX. | 4-COLOR OR RACE. | 5-Single, Married, Widowed, or Divorced, (Write the word.) |
|---|---|---|
| F | W | Single |

6-DATE OF BIRTH. Feb (Month) 16 (Day) 1927 (Year)

7-AGE. ....yrs. ....mos. 3 ds. If LESS than 1 day, ....hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. Stanislaus Kaliszak

11-BIRTHPLACE OF FATHER, (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER. Julia Weber

13-BIRTHPLACE OF MOTHER, (State or Country). Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Stanislaus Kaliszak

(Address) 2008 Monmonier court

15- Filed FEB 20 1927 19.. C. HAMPSON JONES, M. D. Registrar.

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February (Month) 19 (Day) 1927 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxia Liv

(Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ....yrs. ....mos. ....ds.

(Signed) C. Hampson Jones M. D. (Coroner.)

19 27 (Address) 148 N Broad

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

| 19-PLACE OF BURIAL OR REMOVAL. | DATE OF BURIAL. |
|---|---|
| St Stanislaus Cem | Feb 21 1927 |
| 20-UNDERTAKER. | ADDRESS |
| John M Weber | 1803 Bank St |

FEB 20 1927

Spec.—1-12-23—M&T—500 Blks.

ZMUDZIEJEWSKI ✓

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19212

## CERTIFICATE OF DEATH.

118-E001 19212

1-PLACE OF DEATH St Joseph Hospital

CITY OF BALTIMORE: (No. ..... ST. 7-4 ..... WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Zmudjeski

(a) RESIDENCE No. 1744 Bank ST., ..... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 (Single), Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | white | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 1 1889

| 7 AGE 37 Years | Months 5 | Days 17 | If LESS than 1 day, .... hrs. or .... min. |
|---|---|---|---|

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Die Setter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Mikolaj Zmudzieljewski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Frances Wagner

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs Mary Otremba sister

(Address) 1744 Bank St

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/18 f 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan 21, 1927, to Feb 18, 1927, that I last saw him alive on Feb 18, 1927, and that death occurred, on the date stated above, at 11:45 P m.

The CAUSE OF DEATH* was as follows:

① Broncho Pneumonia. Unresolved.

② Chronic Nephritis

Operated upon for Strangulated Inguinal hernia 1/21/27. (duration) ② 2 yrs. ..... mos ..... ds. ① 1

CONTRIBUTORY (Secondary) Ex Lenuskin

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At Home (Nephritis)

Did an operation precede death? yes Date of Jan 21 1927

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Clement B. Moran M. D.

, 19 (Address) St Joseph's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 17 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| St Stanislaus cem | Feb 23 1927 |
| UNDERTAKER John M Weber | ADDRESS 1803 Bank St |

Spec—12-23-21—E.B.R.S.—400 Eks.

19213

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

4E 19213

1-PLACE OF DEATH

City of BALTIMORE: (No. 1915 Division St. 14-P Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosia A. Talson

(a) Residence No. 1915 Division St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 2 mos. 21 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

| 3-SEX | 4-COLOR OR RACE | 5-Single, Married, Widowed, or Divorced, (Write the word.) |
|---|---|---|
| Female | Colored | widow |

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of widow of Thomas A. Talson

6-DATE OF BIRTH (month, day and year) nov 27 1859

| 7-AGE | If LESS than 1 day, |
|---|---|
| 67 yrs. 2 mos. 21 ds. | hrs. or min. |

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country) Maryland

PARENTS.

10-NAME OF FATHER, Zachariah A Banks

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Hester A. Lee

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Edward F. Barnett

(Address) 1915 Division St

15- Filed DEC 20 1927 C. HAMPSON JONES, M. D., Registrar.

Per

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb. 18, 1927

17- I HEREBY CERTIFY, That I attended deceased from December 2, 1926, to February 18 1927, that I last saw h[illegible] alive on Feb 18th 1927 and that death occurred, on the date stated above, at 10-P m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Bronchial)

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Gastric Carcinoma

(Duration) yrs. mos. ds.

18-Where was disease contracted, if not at place of death? on 708 Mount St

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings only

(Signed) J. Bernell Fahey M. D.

. 19 (Address) 2937 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19-PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL, |
|---|---|
| Laurel Cemetery | Feb 21 1927 |
| 20-UNDERTAKER, | ADDRESS |
| Chas. H. Johnson | 416 N. Carlton St. |

Spec.—1-10-21—M&T—1500 Bks.

E 19214

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

57

REGISTERED NO. E 19214

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 607 N. Spring St

CITY OF BALTIMORE: (No. ..... ST., 7-9 WARD)

2-FULL NAME Susan Connor

(a) RESIDENCE NO. 607 N. Spring St ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | col. | widow |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of John Connor

6 DATE OF BIRTH (month, day, and year) 1850

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or ... min. |
|---|---|---|---|---|
| | 77 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer —

9 BIRTHPLACE (city or town) ..... (State or country) Md

PARENTS

10 NAME OF FATHER Joseph Sherwood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown (State or country)

14 Informant Mary E. Gitt.
(Address) 607 N. Spring St.

15 Filed FEB 20 1927 C. HAMPSON JONES, M. D., Registrar
Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-18 1927

17 I HEREBY CERTIFY, That I attended deceased from 12-20-26, 19 ..., to 2-18, 19 27,
that I last saw her alive on 2-17, 19 27,
and that death occurred, on the date stated above, at 12 30 a.m.
The CAUSE OF DEATH* was as follows:

Diabetic Gangrene
Arteriosclerosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical Laboratory
(Signed) Dr B Butler, M. D.
, 19 (Address) 4 yrs N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lf. Potter Cemetery — DATE OF BURIAL Feb. 21 1927

UNDERTAKER Chas. H. Johnson & Co. — ADDRESS 1 N. Carrollton Ave

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19215

## CERTIFICATE OF DEATH.

101-001

E 19215

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 122 Weber St., 24 Ward 33

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Melly.

(a) RESIDENCE NO. 122 Weber St. 24 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married. |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John. Melly.

6 DATE OF BIRTH (month, day, and year) June 5 1862.

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 64 | 8 | 12 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany.

PARENTS

10 NAME OF FATHER not known

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany.

14 Informant John Melly.

(Address) 122 Weber St

Filed 2-20 1927 C. HAMPSON JONES, M. D.

Per Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 17th 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 13, 1927, to Feb 17, 1927, that I last saw h.. alive on Feb 17, 1927, and that death occurred, on the date stated above, at 1.35 P m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John A. Ehrmann, M. D.

19 (Address) 1337 E. Chase St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross a a Co. Date of Burial 2-21 1927

20 UNDERTAKER East B Marks ADDRESS 115 E West St

Very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19216

## CERTIFICATE OF DEATH. 198 ×

E 19216

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Lacty Hospital St. 46-37 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas. Hard.

(a) RESIDENCE NO. Edgwood. Md. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred— yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 3-19-1897

| 7 AGE | Years | Months | Days 24 | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 29 | 10 | 30 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stationary Fireman

( ) General nature of industry, business, or establishment in which employed (or employer) Edgewood. Md

(c) Name of employer 086

9 BIRTHPLACE (city or town) Balto

(State or country) Md

PARENTS

10 NAME OF FATHER Chas Hard.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Ella Mulligan

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Mrs Stella Hetlick

(Address) 931 Homestead St

15 Filed 3 20 1927 C. HAMPTON JONES, M. D.

By Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH was as follows:*

Homicide

Stab Wounds Abdomen

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Shock.

(duration) yrs. mos. ds.

Feb 18 1927 (Signed) Jos Clinton Blades M. D.

(Coroner)

(Address) 143 N Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Union Chapel Cem Harford Co Md Date of Burial 2-21 1927

20 UNDERTAKER David Davidson ADDRESS Upper Falls. Md

Very Important. See Instructions on Back of Certificate.

Spec.—1-12-23—M&T—500 Blks.

W E 175 19217

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

74-001 E 19217

REGISTERED NO.

1-PLACE OF DEATH

JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. 9-19 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph A- Russell

(a) RESIDENCE NO. 5-30-E-20th ST. City WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Oda. Russell.

6 DATE OF BIRTH (month, day, and year) Sept 2 1855

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min |
|---|---|---|---|---|
| | 71 | 5 | 17 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md -

PARENTS

10 NAME OF FATHER Joseph Russell

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER Mary Hill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Records — (Address) JOHNS HOPKINS HOSPITAL

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

FEB 26 1927 By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 12, 1927, to Feb 19, 1927.

that I last saw h alive on Feb 19, 1927

and that death occurred, on the date stated above, at 12 25 A. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Myocardial Failure

Prostatic Hypertrophy

(duration) ? yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis.

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) F. W. Schacht, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Havre de Grace Md. | 2-21 1927 |
| 20 UNDERTAKER J A Pennington & Son Havre de Grace Md. | ADDRESS |

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19218

## CERTIFICATE OF DEATH.

X 10 -001

E 19218

1-PLACE OF DEATH U. S. Marine Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Baltimore, Md ST. 12-51 WARD)

2-FULL NAME Joseph Tarsin

(a) RESIDENCE NO. 1053 Constance St ST. New Orleans, La WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 2 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | white | single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1896.

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 31 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) Foreman of

(c) Name of employer S/S Hamana

9 BIRTHPLACE (city or town) (State or country) La

PARENTS

10 NAME OF FATHER Wilton Tarsin

11 BIRTHPLACE OF FATHER (city or town) (State or country) La

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Self.

(Address)

15 FILED 3 28 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 17 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 24, 1927, to Feb 17, 1927, that I last saw h— alive on Feb 17, 1927, and that death occurred, on the date stated above, at 4:25 m.

The CAUSE OF DEATH* was as follows:

Left Lobar Pneumonia

O.A. Corner J. Dorrussey

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Hypertrophy Cirrhosis of the Liver (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? In U.S. Marine Hospital

Did an operation precede death? no Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) C. L. Williams M. D.

Feb 18, 1927 (Address) U.S. Marine Hospital Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary's Hampden

DATE OF BURIAL Feb 21 1927

20 UNDERTAKER E. LeRoy Stiffler

ADDRESS 125 N. Mott Ave

Spec.—1-12-23—M&T—500—Blks.

200213

E 19219

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

+ 49

E 19219

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) JOHNS HOPKINS HOSPL ST., 7-9 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Belk

(a) RESIDENCE No. South White St ST Lancaster Pa.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5° ds. How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1905

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or ——— |
|---|---|---|---|---|
| | 21 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer in O&O

(b) General nature of industry, business, or establishment in which employed (or employer): Cotton Mills

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Joseph Belk

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Lou McManus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Records
(Address)

15 Filed FEB 20 19 R.L. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 19 19 27

17 I HEREBY CERTIFY, That I attended deceased from Feb. 14, 19 27, to Feb. 19, 19 27

that I last saw him alive on Feb. 19, 19 27

and that death occurred, on the date stated above, at 6 P m

The CAUSE OF DEATH* was as follows:

Tumor of the brain

(duration) 1 yrs — mos — ds

CONTRIBUTORY (Secondary) none (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? At deceased's home

Did an operation precede death? yes Date of Feb 19, 1927

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Anatole Koloditzy M. D.

2-20, 19 27 (Address) Johns Hopkins Hospital Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lancaster S.C.

DATE OF BURIAL 2/19/27 19

20 UNDERTAKER Jos. Lehrers

ADDRESS 221 Ray

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19220

## CERTIFICATE OF DEATH.

89 E 19220

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 138 N. Hare (St.) 6-11 (Ward)

2-FULL NAME Thomas J. Terry

(a) RESIDENCE NO. 138 N. Hare ST. WARD

(If usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice Terry

6 DATE OF BIRTH (month, day, and year) Sept. 3- 1852

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 74 | 5 | 15 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Annapolis, Md

PARENTS

10 NAME OF FATHER dont know

11 BIRTHPLACE OF FATHER (city or town) (State or country) dont know

12 MAIDEN NAME OF MOTHER dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) dont know

14 Informant Charles E. Rosenthal

(Address) 138 N. Hare St.

15 Filed 2-20-1927, 19 C. HARRISON JONES, M. D. Registrar

Per R.K.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 18 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan. 1st, 1927, to Feb. 18, 1927, that I last saw him alive on Feb. 18, 1927 and that death occurred, on the date stated above, at 4 45 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene L. Cassard, M. D.

2.19.27. 19 (Address) 514 Druid Lane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Ann's Cemtery annapls Md

DATE OF BURIAL 2/21 1927

20 UNDERTAKER Zirkler + Zirkler

ADDRESS 1739 E Eager St

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19221

## CERTIFICATE OF DEATH.

84 E 19221

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1720 Cole ST. 19-28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam Noweck

(a) RESIDENCE No. 1720 Cole ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louisa R. Noweck

6 DATE OF BIRTH (month, day, and year) Mar.22, 1864

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 62 | 10 | 24 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) Davidson Chemical

(c) Name of employer Company

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Louis Noweck

(Address) 1720 Cole Street

15 Filed 19 Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb.18 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 15, 1927, to Feb 18, 1927, that I last saw him alive on Feb 17, 1927, and that death occurred, on the date stated above, at 12.30 AM

The CAUSE OF DEATH* was as follows: Angina Pectoris

CONTRIBUTORY (Secondary) Pulmonary Oedema (duration) 2 yrs. mos. ds.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Heart + pulmonary

(Signed) James R Lazzell M. D.

2-18, 1927 (Address) 1729 W. Lombard St.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Feb.21 27

20 UNDERTAKER Joseph B Cook — ADDRESS 1003 N Eutaw St

8 20 1927 H. HAMPTON JONES, M. D.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19222

## CERTIFICATE OF DEATH.

89 E 19222

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2920 Mosher ST. 16-67 (WARD)

2-FULL NAME Charles J. Brown

(a) RESIDENCE No. 2920 Mosher St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Adna E. Brown

6 DATE OF BIRTH (month, day, and year) Feb. 1, 1879

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 48 | xxx | 17 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Thomas Brown

11 BIRTHPLACE OF FATHER (city or town) Philadelphia, (State or country) Penna.

12 MAIDEN NAME OF MOTHER Sophia C. Meyer

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland.

14 Informant Thomas Brown (Address) 2006 W. Lexington St. W

15 Filed FEB 20 1927 HAMPSON JONES, M. Registrar Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 18, 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 17, 1927, to Feb 18, 1927, that I last saw him alive on Feb 17, 1927, and that death occurred, on the date stated above, at 5.45 a. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Senile Insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Med

(Signed) ... M. D.

2-18-27 (Address) 517 Scott St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL Feb. 21 1927

20 UNDERTAKER Joseph T. Cook — ADDRESS 1003 W. Balto St.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

# E 19223

CERTIFICATE OF DEATH

44 E 19223

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 2006 Pont ave St. 13-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Hamilton Hopper

(a) RESIDENCE NO. 2006 Park ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth Hopper

6 DATE OF BIRTH (month, day, and year): Dec 3 - 1856

7 AGE: Years 70 Months 1 Days 25

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto Co

(State or country): Md

PARENTS

10 NAME OF FATHER: Thos. H. Hopper

11 BIRTHPLACE OF FATHER (City or town): Balto Co

(State or country): Md

12 MAIDEN NAME OF MOTHER: Frances Wilson

13 BIRTHPLACE OF MOTHER (city or town): Balto Co

(State or country): Md

14 Informant: Dan'l H. Hopper

(Address) 2006 Pont Ave

Filed FEB 21 1927 C. HAMILTON JONES, M. D.

Per ..... Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1st, 1926, to Feby 18th, 1927.

that I last saw him alive on Feby 18th, 1927.

and that death occurred, on the date stated above, at 2 30 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 10 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Stilson F. Hellman M. D.

. 19 (Address) 6 East Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

Date of Burial: Feb 21 1927

20 UNDERTAKER: H. T. Tudor & Son

ADDRESS: Balto

very important. See instructions on back of certificates.

Spec.—1-12 23—M&T—500 Bks.

E 19224 HEALTH DEPARTMENT—CITY OF BALTIMORE 9

CERTIFICATE OF DEATH. 179 E 19224

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2529 Salem ST., 1954 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard A. Rigg

(a) RESIDENCE NO. 2529 Salem ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isabel H. Rigg

6 DATE OF BIRTH (month, day, and year) March, 9" 1852

| 7 AGE Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|
| 74 | 11 | 11 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Cecil Co.
(State or country) Maryland

PARENTS

10 NAME OF FATHER Robert Rigg

11 BIRTHPLACE OF FATHER (city or town) Chester Co.
(State or country) Penn.

12 MAIDEN NAME OF MOTHER Lydia Ann Brommell

13 BIRTHPLACE OF MOTHER (city or town) Chester Co.
(State or country) Penn.

14 Informant Mrs. Mabel L. Cardwell
(Address) 2529 Salem Streett

15 Filed FEB 21 1927 C. HAMPTON JONES, M. D. Registrar
For: K K

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 20 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 11, 1927 to Feb 19, 1927

that I last saw h[illegible] alive on Feb 19, 1927

and that death occurred, on the date stated above, at Feb 20 3.3[illegible] m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm Lindler M. D.

, 19 (Address) 2348 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem.

DATE OF BURIAL Feb. 22, 27

UNDERTAKER Joseph B. Cook

ADDRESS 1003 W. Balto St.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19225

## CERTIFICATE OF DEATH.

90V E 19225

1-PLACE OF DEATH

City of BALTIMORE: (No. 1610 Barclay St., 12-14 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob S. Smith

(a) RESIDENCE NO. 1610 Barclay St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of): Florida

6 DATE OF BIRTH (month, day, and year): April 29, 1862

7 AGE: Years 64 Months 9 Days 21 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer): Self

(c) Name of employer

9 BIRTHPLACE (city or town): Md.

(State or country)

PARENTS

10 NAME OF FATHER: Jno S. Smith

11 BIRTHPLACE OF FATHER (city or town): Ger.

(State or country) Germany

12 MAIDEN NAME OF MOTHER: Clara (?) Steiger

13 BIRTHPLACE OF MOTHER (city or town): Germany

(State or country)

14 Informant: Florida Smith

(Address): 1610 Barclay

15 Filed.....19..... Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 18 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valv. dis. heart

1 mo

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) acute cardiac dilatation

(duration) .....yrs. .....mos.

(Signed) W. J. Reese M.

(Coroner)

Apr. 20, 19 27 (Address) 1639 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet — Date of Burial: Feb 22, 1927

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E. Monument

Very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19226

## CERTIFICATE OF DEATH

31

E 19226

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1910 Riggs Ave. 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Coale

(a) RESIDENCE NO. 1910 Riggs Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S. if of foreign birth 50 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm Coale

6 DATE OF BIRTH (month, day, and year): June 10/1854

7 AGE: Years 72 Months 8 Days 8 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Raleigh N. C.

PARENTS

10 NAME OF FATHER: Peter Francis

11 BIRTHPLACE OF FATHER (City or town) (State or country): N. C.

12 MAIDEN NAME OF MOTHER: Jennie Mann

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. C.

14 Informant: John H. Ruffel (Address) 42 Cor Riggs Ave

15 Filed ..... 19 ..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feby 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 16, 1927, to Feb. 18, 1927, that I last saw h[illegible] alive on Feb. 18, 1927, and that death occurred, on the date stated above, at 10:30 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P. E.

(Signed) Hamon C. Todd, M. D.

Feb. 19 27 (Address) 735 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loganville Cem. Date of Burial Feby 22 1927

20 UNDERTAKER: Williamhood & Son ADDRESS 502 E. Baltimore

very important. See instructions on back of certificates.

FEB 21 1927 C. HAMPSON [illegible] Registrar

By

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

16/001

**E 19227**

## CERTIFICATE OF DEATH.

**E 19227**

1- PLACE OF DEATH Mt. Hope Hospital

CITY OF BALTIMORE: (No. 2 ST. 16-68 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2- FULL NAME Baby Moberly

(a) RESIDENCE No. 2712 Manchester ST., 1 WARD
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Baby

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) 2-18-27

7 AGE — Years — Months — Days: 1 — If LESS than 1 day, 15 hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ✓ do
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer ✓

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Wilbur Moberly

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Ruth

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Mrs. Mary Moberly
(Address) 2712 Manchester St

15 Filed FEB 21 1927 C. HAMPSON JONES, M. D. Registrar
By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-19 1927

17 I HEREBY CERTIFY, That I attended deceased from 2-18, 1927, to 2-19, 1927, that I last saw him alive on 2-19, 1927, and that death occurred, on the date stated above, at 3:05 P. m.

The CAUSE OF DEATH* was as follows:
Premature birth
(6 mos.)

(duration) yrs. mos. ds.

CONTRIBUTORY ✓
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno A Hampson, M. D.

, 19 (Address) Mt Hope Hospt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary's Complex — DATE OF BURIAL Feb 21 1927

20 UNDERTAKER Wm Cook — ADDRESS 502 E Madison

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

**E 19228**

**CERTIFICATE OF DEATH.**

**E 19228**

1-PLACE OF DEATH Mercy Hospital — 11-24

REGISTERED NO.

City of BALTIMORE: (No. ____ St., ____ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John A Richardson

(a) RESIDENCE NO. 33 W. Preston St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed or Divorced. (write the word): Widowed

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Miriam S Richardson

6 DATE OF BIRTH (month, day, and year): Aug 20. 1847

7 AGE: Years 79 | Months 5 6 | Days 29 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Real Estate, Retired

(b) General nature of industry, business, or establishment in which employed (or employer): 045

(c) Name of employer

9 BIRTHPLACE (city or town) ____ (State or country) Balto Md

PARENTS

10 NAME OF FATHER: Edward Richardson

11 BIRTHPLACE OF FATHER (city or town) ____ (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) ____ (State or country) Balto Md.

14 Informant: Johns Richardson

(Address) Catonsville Md.

Filed FEB 21 1927 E. HAMPTON JONES, M. D. Registrar

**MEDICAL CERTIFICATE OF DEATH**

16 DATE OF DEATH (month, day, and year) Feb 19 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb 15 1927, to Feb 19, 1927, that I last saw h— alive on Feb 19, 1927, and that death occurred, on the date stated above, at 5.55 P. m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Senility

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ____ Date of ____

Was there an autopsy? ____

What test confirmed diagnosis? ____

(Signed) E Hampton Jones, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury; and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — Date of Burial: Feb 22 1927

UNDERTAKER: J. Cook — ADDRESS: 507 E North Ave.

Very important. See instructions on back of certificates.

Spec. –7-17-26--A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 19229

100-001

REGISTERED NO. E 19229

1-PLACE OF DEATH

City of BALTIMORE: (No.) 2810 Rayner Ave (St.) (Ward) 1668

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martin L Tillery

(a) RESIDENCE NO. 2810 Rayner Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) ~~WIFE of~~: Josephine Tillery

6 DATE OF BIRTH (month, day, and year): July 3- 1852

7 AGE: Years 74 Months 7 Days 15 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Carrier mfg Co

(c) Name of employer: Factory

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: John Tillery

11 BIRTHPLACE OF FATHER (City or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Kate Fischer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Josephine Tillery (Address) 2810 Rayner Ave

15 Filed FEB 21 1927 C. HAMPSON GIBNEY, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 3 1927 to Feb 18 1927.

that I last saw h~~im~~ alive on Feb 18 1927.

and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia.

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Generalized Atherosclerosis

Myocardial degeneration

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no. Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) W. Mitchell M. D.

Feb 19 1927 (Address) 2901 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — Date of Burial 2/24 1927

20 UNDERTAKER: W S Cook — ADDRESS 5025 Park

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19230

## CERTIFICATE OF DEATH.

51

E 19230

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Josephs Hospital (ST.) 8-45 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John White

(a) RESIDENCE NO. 1625 Darley Ave (ST.) (WARD)

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Evelyn C White

6 DATE OF BIRTH (month, day, and year) Nov 10. 1854

7 AGE: Years 72. Months 3 Days 9 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Ships steward, retired

(b) General nature of industry, business, or establishment in which employed (or employer): 009

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): England

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: Mrs Ed Schwartz
(Address) 1625 Darley Ave.

15 Filed FEB 21 1927 HAMPSON JONES, M. D. Registrar
By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 17, 1927, to Feb 19, 1927, that I last saw him alive on Feb 19, 1927, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Diabetic Gangrene of Rt Foot -

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Diabetes

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) Elmer R. Wooden, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Forest

DATE OF BURIAL: Feb 22 1927

20 UNDERTAKER: J. Cook

ADDRESS: 507 E. Fayette Ave.

Spec.—7-17-26—A Co.—200 Bks.

Dr France 2939 McElderry St

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

**E 19231** REGISTERED NO. 1 27 19231

1-PLACE OF DEATH

City of BALTIMORE: (No.) 109 S Belair Rd St.. Ward 27-41 Gardenville

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Gegner

(a) RESIDENCE NO. 109 S. Belair Rd St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced. (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Gegner

6 DATE OF BIRTH (month, day, and year): Dec 28, 1837

7 AGE: Years 89 Months 1 Days 21 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of Industry, business, or establishment in which employed (or employer): 60

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Eliz Kratz

(Address) 109 S Belair Rd

15 Filed ..... 19..... H. HARRISON JONES, M. D.

Registrar

FEB 21 1927

Per R.C.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Feby 18, 1927, to Feby 19, 1927, that I last saw h.. alive on 2/19- 1927, and that death occurred, on the date stated above, at 5 PM m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr Int Nephs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr France, M. D.

(Address) 2939 McElderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel — Date of Burial 2/21 19 27

20 UNDERTAKER: Wm Cook — ADDRESS 502 E North Ave

Very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19232

## CERTIFICATE OF DEATH

129

E 19232

1-PLACE OF DEATH 1622 W Saratoga St

CITY OF BALTIMORE: (No. 1622 ST. W. WARD 19-27)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bettie Watkins

(a) RESIDENCE NO. 1622 W Saratoga St ST., WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE: Years 60 | Months Unknown | Days | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Unemployed
(b) General nature of industry, business, or establishment in which employed (or employer): 000
(c) Name of employer

9 BIRTHPLACE (city or town) Charlottesville
(State or country) Va

PARENTS

10 NAME OF FATHER Wat Jones

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Va

14 Informant Augustus Medors
(Address) 1622 W. Saratoga St

15 Filed ... 19 C. HAMPTON JONES, M. D. Registrar
8 2 1927 By .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1926 to Jan 19, 1927.
that I last saw h[illegible] alive on Jan 18, 1927
and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs. 2 mos 9 ds.

CONTRIBUTORY
(Secondary)
(duration) 2 yrs. 2 mos. 2 ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Examination
(Signed) C. Hampton Jones, M. D.
, 19 (Address) 1622 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: Jan 21 1927

20 UNDERTAKER: Daniel Easter — ADDRESS: [illegible]

Spec. -7-17-26 —A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19233

## CERTIFICATE OF DEATH

129 E 19233

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 3515 Cedar Ave St. 13-52 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane B. Pearce

(a) RESIDENCE NO. 3515 Cedar Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of: George L. Pearce

6 DATE OF BIRTH (month, day, and year): Dec 10, 1837.

7 AGE: Years 89 Months 2 Days 10 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): 86

(c) Name of employer

9 BIRTHPLACE (city or town): Md.

(State or country)

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (City or town): Unknown

(State or country)

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): Unknown

(State or country)

14 Informant: Mrs. Marshall L. Spicer

(Address) 3515 Cedar ave

15 Filed FEB 21 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 20. 19 27

17 I HEREBY CERTIFY, That I attended deceased from Feb 17, 19 27, to Feb 20, 19 27.

that I last saw her alive on Feb 19, 19 27.

and that death occurred, on the date stated above, at 10 30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis & Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) H. von Dreusch M. D.

2/21, 19 27 (Address) 846 W 36 St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Marys Hampden

Date of Burial: Feb 23 19 27

20 UNDERTAKER: Ehrenworth's Son

ADDRESS: 3615 Elston Ave

very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

E 19234 HEALTH DEPARTMENT—CITY OF BALTIMORE 100-001

CERTIFICATE OF DEATH. E 19234

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3512 Benson ST. 13-57 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 8.)

2-FULL NAME Elsworth Perrymen

(a) RESIDENCE No 3512 Benson. ST., 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 18, 1927

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | | 1 | | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Jack Markley.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Myrtle Perrymen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

Informant Cora Perrymen
(Address) 3512 Benson St.

Filed 2 1 1927 C. HAMPSON JONES, M. D. Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/18 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said Inquest (inquest, autopsy or inquiry) find that said deceased came to h-s death on the date stated above.

The CAUSE OF DEATH* was as follows:
Bronchopneumonia
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) John F. Morrison, M. D.
Coroner
2/18, 1927 (Address) 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.
Where was disease contracted, if not at place of death?
Former or usual residence

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| St. Marys Hampden | Feb 19 1927 |
| 20 UNDERTAKER Chenoweth Bros | ADDRESS 3615 Chestnut ave |

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 19235

3/ E 19235

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 28 S. Carlton St. 18-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Moore,

(a) RESIDENCE NO. 28 S. Carlton St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1877

7 AGE: Years 50 Months Days IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Jos. Burgess

(c) Name of employer: Packett

9 BIRTHPLACE (city or town)

(State or country): Balto.

PARENTS

10 NAME OF FATHER: Daniel Moore

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Balto.

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant: Josh Ferguson

(Address): 1521 Lexington St

15 Filed FEB 21 1927 19 C. HAMPSON JONES M. D. Registrar

By RFC

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 16 19 27

17 I HEREBY CERTIFY, That I attended deceased from January 14, 1927, to Feb 16, 1927, that I last saw him alive on January 15, 1927, and that death occurred, on the date stated above, at 5 4. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 2 mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? What test confirmed diagnosis? Myroscope

(Signed) Jas L Stevens M. D.

2. 18. 1927 (Address) 562 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — Date of Burial: Feb 21st 1927

20 UNDERTAKER: C. Jones — ADDRESS: 1114 Gilmor

very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19236

## CERTIFICATE OF DEATH.

57 E 19236

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2626 Lyola South Ave St.) (15-5 WARD)

2-FULL NAME Mary Smith

(a) RESIDENCE No. 2626 Lyola South Ave St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | W | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Abraham Smith

6 DATE OF BIRTH (month, day, and year) 1878

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 49 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Elya Feinberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Lindeen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Abraham Smith

(Address) 2626 Lyola South Ave

15 Filed ..... 19 ..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/20 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 19 1927, to Feb. 20 1927,

that I last saw her alive on Feb. 20 1927

and that death occurred, on the date stated above, at 5:05 P m

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) Diabetes, Nephritis (Cath. Bladder)

(duration) 8 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Phys. & Lab. Exam

(Signed) Harry Lindeen M. D.

, 19 (Address) 2421 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Int. Corp.

DATE OF BURIAL 2/21 1927

20 UNDERTAKER Jack Levin

ADDRESS 1439 E Baltimore St

Spec.—1-10-21—M&T—1500 Bks.

Dorne.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19237

## CERTIFICATE OF DEATH.

129

E 19237

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Marguerite Dorne ST. 15-21 WARD)

2-FULL NAME 1456 N. Carey

(a) RESIDENCE No. 1456 N. Carey ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 ?, yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Colored | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Abraham Dorne

6 DATE OF BIRTH (month, day, and year) Feb 16 1859

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or min. |
|---|---|---|---|---|
| | 68 | 0 | 2 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) ✓ 037 Chronic Interstitial Nephritis

(c) Name of employer ✓ Self. (duration) yrs. 5 mos. ds.

9 BIRTHPLACE (city or town) (State or country) New Market Md

PARENTS

10 NAME OF FATHER James Stanley

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Market Md

12 MAIDEN NAME OF MOTHER Annie Young

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Market Md

14 Informant Marguerite Dorne

(Address) 1456 N Carey St

15 Filed FEB 21 1927 HAMPSON JONES M. Registrar

By R. C. B.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 15 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1927, to Feb 18, 1927, that I last saw her alive on Feb 17, 1927 and that death occurred, on the date stated above, at 6.25 P. m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis (duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Age - arteriosclerosis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms - Physical

(Signed) Wm H. Frigat M. D.

Feb 19, 1927 (Address) 1209 Park Ave S

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Att. Auburn Cem

DATE OF BURIAL 2/21/27

20 UNDERTAKER Emmett Hensley

ADDRESS 528 N. Eden

Form 1 Rev. 1-10-21—M&T—1500 Bks.

Directions: Use only black ink. Write plainly. Fill all blanks. Use ditto marks only when they will not be misunderstood. Be very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 19238

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19238

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5 North 6th St., ~~Broadway~~ 5425 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Frambach

(a) RESIDENCE NO. 5 North 6th ST., 75 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas. A Frambach

6 DATE OF BIRTH (month, day, and year) Sept 11 1861

| 7 AGE Years | Months | Days | If LESS than 1 day, ....hrs or ....min. |
|---|---|---|---|
| 65 | 5 | 7 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Wamboff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Gertrude Fleckenstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Frank Wamboff

(Address) 1827 Gilmore St

Filed FEB 21 1927 H. LAMAR JONES, M. D. Registrar

Per R R

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 25 1927, to Feb. 18 1927, that I last saw her alive on Feb. 18 1927, and that death occurred, on the date stated above, at 7 1/2 P. m.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation.

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Wilhelm D Groth, M. D.

Feb 24 1927 (Address) 816 Pennington ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross A. A. Co. Md — DATE OF BURIAL FEB 22 1927

UNDERTAKER John F Denny — ADDRESS 715 Lig. St.

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19239

## CERTIFICATE OF DEATH.

100-001

E 19239

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2620 Frederick Ave ST. 20-69 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Allen M North

(a) RESIDENCE NO. 2620 Frederick Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. — mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 13 1926

| 7 AGE | Years | Months | Days | If LESS than 1 day, .... hrs. or .... min. |
|---|---|---|---|---|
| | 1 | — | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Belvy North

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wingate Ind.

12 MAIDEN NAME OF MOTHER Elizabeth Harrison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Holland Island Md

14 Informant Mr Belvy North

(Address) 2620 Frederick Rd

15 Filed FEB 21 1927 C. HAMPSON JONES, M. D. Registrar

By R H

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 2, 1927, to Feb 19, 1927, that I last saw him alive on Feb 18, 1927, and that death occurred, on the date stated above, at 7 15 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pneumonia

Pulmonary

Bronchitis (duration) yrs. 1½ mos ds.

CONTRIBUTORY (Secondary) Insanity and Senility (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C Hayn, M. D.

2/20 1927 (Address) 12 E Hamilton St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cambridge Md

DATE OF BURIAL FEB. 21 1927

UNDERTAKER John F Denny

ADDRESS 715 Light St

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19240

## CERTIFICATE OF DEATH.

11-001 E 19240

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1335 E Clement St. 24-35 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Duffy

(a) RESIDENCE NO. 1335 E Clement ST., ..... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.
(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | white | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Duffy.

6 DATE OF BIRTH (month, day, and year) Sept 15. 1864

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 62 | 5 | 4 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 0 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lawson, Butts Co Md.

PARENTS

10 NAME OF FATHER John Hughes.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Higgins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Mary Peterson
(Address) 1335 Clement St

15 Filed FEB 21 1927 19..

C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 19 1927

17 I HEREBY CERTIFY, That I attended deceased from February 16, 1927, to February 19 1927,

that I last saw her alive on Feb- 19, 1927,

and that death occurred, on the date stated above, at 4-45 P. m.

The CAUSE OF DEATH* was as follows:

Influenza.
Later Pneumonia
Mitral Regurgitation

(duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary) Influenza.

(duration) ... yrs. ... mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) Thos J. Stivers, M. D.

2-20 1927 (Address) 2878 Trafford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem.

DATE OF BURIAL Feb 22 1927

UNDERTAKER Chas L. Stivers

ADDRESS 1501 Park Ave

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19241

## CERTIFICATE OF DEATH.

100-001

E 19241

REGISTERED NO.

1-PLACE OF DEATH U. M. Hospitals

CITY OF BALTIMORE: (No. 33rd & Calvert ST., 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Becker

(a) RESIDENCE No. 2017 Robb. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 10 ds. How long in U. S., if of foreign birth? yrs. 6 mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) August 10th 1926

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | | 6 | 10 | 9 |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Andrew Becker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Grace Sinclair

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Andrew Becker

(Address) 2017 Robb St

15 Filed 2-21-1927 C. HAMPSON JONES, M. D. Registrar

By —

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-19-1927

17 I HEREBY CERTIFY, That I attended deceased from 2-18, 1927, to 2-19, 1927, that I last saw him alive on 2-19, 1927, and that death occurred, on the date stated above, at 8:00 a m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia - (Bilateral

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No.

What test confirmed diagnosis? None

(Signed) Irving A. Faynton, M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL 2/22 1927

20 UNDERTAKER George J. Ruth

ADDRESS 1735 Harford Ave

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

49 E 19242

E 19242 REGISTERED NO.

1-PLACE OF DEATH Colonial Apts.

City of BALTIMORE: (No. 1510 Aisquith St., 9-18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlotte Bull

(a) RESIDENCE NO. 1510 Aisquith St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James B Bull

6 DATE OF BIRTH (month, day, and year): 10/5 1869

7 AGE: Years 57 Months 4 Days 13 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(r) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Marion Jones

11 BIRTHPLACE OF FATHER (City or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Charlotte Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: James B. Bull

(Address): 1510 Aisquith St

15 Filed ..... 19..... Registrar

B 2 1 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/18 1927

17 I HEREBY CERTIFY, That I attended deceased from 2/13/27 to 2/18/27

that I last saw her alive on 2/17/27

and that death occurred, on the data stated above, at 8 05 A m.

The CAUSE OF DEATH* was as follows:

Gastric Hemorrhage

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Abdominal Carcinomatosis

7 (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 2/15/27

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) John W. Graham M. D.

(Address) 610 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — Date of Burial: Feb 21 1927

20 UNDERTAKER: Geo. F. Roth — ADDRESS: 1735 Harford Ave.

very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

Dileo

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19243

## CERTIFICATE OF DEATH

E 19243

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 110 S Sixth (St.) (Ward) 96-37

2-FULL NAME Michael Dileo

(a) RESIDENCE NO. 110 S Sixth ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? 13 yrs. 1 mos. 14 ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) January 5 1914

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 13 | 1 | 14 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoe Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. Va

PARENTS

10 NAME OF FATHER Nicholas Dileo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Elizabeth Cebramonio

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Philadelphia Pa

14 Informant (Address) Nicholas Dileo 110 Sixth

15 Filed 2 1 1927 C. HAMPTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 19 1927

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1926, to Feb. 19, 1927, that I last saw h— alive on Feb. 19, 1927, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) C. Artigiani M. D.

19 (Address) 2942 E Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL Feb 22, 1927

20 UNDERTAKER Wendel Dippel & Son — ADDRESS 378 Penna

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19244

## CERTIFICATE OF DEATH.

31

E 19244

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1111 So. Carey St. 21-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward R. Englese

(a) RESIDENCE NO. 1111 So. Carey St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clara Englese

6 DATE OF BIRTH (month, day, and year) Jan 13th 1890

| 7 AGE Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|
| 37 | 1 | 3 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ice Dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country)

PARENTS

10 NAME OF FATHER John Englese

11 BIRTHPLACE OF FATHER (city or town) Unknown

(State or country)

12 MAIDEN NAME OF MOTHER Catherine Downs

13 BIRTHPLACE OF MOTHER (city or town) Unknown

(State or country)

14 Informant Clara Englese

(Address) 1111 So. Carey St.

Feb 21 1927 C. HAMILTON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 17th 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest

.....find that said deceased came to his death by

(Inquest, autopsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 14 months

CONTRIBUTORY (Secondary) Heart failure

(duration) mos. ds.

(Signed) Thos. R. Norton M. D.

(Coroner)

19 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury; and (2) Whether Accidental, Suicidal, or Homicidal. (Refer also to additional information.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Date of Burial 2/21/27

20 UNDERTAKER Harry A. White ADDRESS 831 W. Lombard St.

Very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19245

## CERTIFICATE OF DEATH.

131

E 19245

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3926 Ridgewood Ave 15-66 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Alexander Russell

(a) RESIDENCE NO. 3926 Ridgewood Ave Ward

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. 8 mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Gertrude Russell

6 DATE OF BIRTH (month, day, and year): Oct 29 1875

7 AGE — Years: 51 | Months: 3 | Days: 28 | If LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Factory Storekeeper

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town): Reisterstown

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Wm A Russell

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Pennsylvania

12 MAIDEN NAME OF MOTHER: Abbie Thomas

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Northumberland Pa

14 Informant: Harry Russell

(Address): Baltimore Md

15 Filed ..... 19 C. HAMPSON JONES, M. D. Registrar

21 1927 Per J.C.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 18, 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1926, to Feb 18, 1927, that I last saw h.. alive on Feb 18, 1927, and that death occurred, on the date stated above, at 6.20 P m.

The CAUSE OF DEATH* was as follows:

Pyelitis

(duration) ..... yrs. 4 mos. ds.

CONTRIBUTORY (Secondary): Myocardial Insufficiency

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) J. N. Wilson M. D.

, 19 (Address) 823 N 36th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — Date of Burial: Feb 21 1927

20 UNDERTAKER: J. F. Elmer & Sons — ADDRESS: Reisterstown Md

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 19246 HEALTH DEPARTMENT—CITY OF BALTIMORE E 19246

101-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1321 Herkmer ST. 21-24 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ANDRUS DAVKSA

(a) RESIDENCE No. 1321 Herkmer ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Selomia Badicute

6 DATE OF BIRTH (month, day, and year) No. 1874

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 53 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor 640

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B.O.R.R.

9 BIRTHPLACE (city or town) (State or country) Lithvania

PARENTS

10 NAME OF FATHER No.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithvania

12 MAIDEN NAME OF MOTHER No.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithvania

14 Informant Selomia Davksa
(Address) 1321 Herkmer Street

Filed FEB 21 1927 H. M. JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 14, 1927, to Feb 18, 1927.

that I last saw h[illegible] alive on Feb [illegible], 19[illegible].

and that death occurred, on the date stated above, at 2.30 p m.

The CAUSE OF DEATH* was as follows:

Labor Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Signs + Symptoms

(Signed) [illegible] M. D.

2/19, 1927 (Address) 371 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislowas — DATE OF BURIAL: Feb. 22. 1927

UNDERTAKER: John Grebliauckas — ADDRESS: 1423 S. Paca St

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 19247

1-PLACE OF DEATH

City of BALTIMORE: (No. 2722 Elliott St. 1-3 Ward)

2-FULL NAME Lama A. Cramer

(a) RESIDENCE NO. 2722 Elliott St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. If of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

REGISTERED NO. 11 E 19247

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank M. Cramer

6 DATE OF BIRTH (month, day, and year): April 16, 1869

7 AGE — Years: 57 Months: 9 Days: 22 21

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home 27

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md.

PARENTS

10 NAME OF FATHER: Wm. H. Sinclair

11 BIRTHPLACE OF FATHER (City or town): Balto

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Louisa A. Barker

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country): Md.

14 Informant: May Hohmeier

(Address) 606 S. Ewing St

15 Filed FEB 21 1927

C. Hamilton JONES, M. D.

Registrar

Per R.K.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 17. 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 15 1927, to Feb 17 1927,

that I last saw h.. alive on Feb 17 1927,

and that death occurred, on the date stated above, at 7.25 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

Influenza (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Data of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. J. Davidson, M. D.

, 19 (Address) 3035 Adonnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cemetery — Date of Burial: Feb. 21 1927

20 UNDERTAKER: Henry Sander & Sons Inc. — ADDRESS: 1710 Fleet St.

very important. See instructions on back of certificates.

E 19248

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

REGISTERED NO. E 19248

1-PLACE OF DEATH Mercy Hospital

City of BALTIMORE: (No. 1604 N. Payson St. 15-21 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Lowry

(a) RESIDENCE NO. 1604 N. Payson St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret M. Lowry

6 DATE OF BIRTH (month, day, and year): Nov. 1. 1884

7 AGE: Years 44 | Months 3 | Days 19 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman. 66

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: T. L. Webb.

9 BIRTHPLACE (city or town):

(State or country): Baltimore

PARENTS

10 NAME OF FATHER: Wm. J. Lowry

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Wheeling W. Va.

12 MAIDEN NAME OF MOTHER: Catherine E. Button

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Baltimore Co. Md.

14 Informant: Margaret M. Lowry

(Address): 1604 N. Payson St.

15 Filed 19 Registrar.

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 20 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 9 1927, to Feb. 20 1927, that I last saw him alive on Feb. 20 1927, and that death occurred, on the date stated above, at 2:55 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Hepatitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — Date of Burial: Feb. 23 1927

20 UNDERTAKER: Henry Sander & Sons Inc — ADDRESS: 1710 Fleet St.

FEB 21 1927 C. HARTWOOD, M.D. Registrar

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19249

## CERTIFICATE OF DEATH

131 E 19249

1-PLACE OF DEATH

REGISTERED NO. 12-51

City of BALTIMORE: (No. 2210 N. Charles St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude Paul

(a) RESIDENCE NO. 2210 N. Charles St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Joseph Paul

6 DATE OF BIRTH (month, day and year): February 2nd 1863

7 AGE — Years: 64 — Months: — Days: 17

IF LESS than 1 day ... hrs. or ... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer): 37

(c) Name of employer

9 BIRTHPLACE (city or town): Balto Co. Md.

(State or country)

PARENTS

10 NAME OF FATHER: George Heckendroffer

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Gertrude Whitere

13 BIRTHPLACE OF MOTHER (City or town)

(State or country): Germany

14 Informant: Mr. Kuper

(Address) 2210 N. Charles St.

15 Filed ... 19... C. HAMPTON JONES, M. D. Registrar

For ...

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): February 19 — 1927

17 I HEREBY CERTIFY, That I attended deceased from June 1st, 1926, to Feb 19th, 1927,

that I last saw her alive on Feb. 19th, 1927,

and that death occurred, on the date stated above, at 7:00 P. m.

The CAUSE OF DEATH* was as follows:

Cysts - Cystitis

Colon Bacillus General infection

(duration) ... yrs. 8 mos — ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) J. A. Chatard, M. D.

Feb 20. 1927 (Address) 300 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

Date of Burial: 2/22 1927

20 UNDERTAKER: Chas F. Mace & Son

ADDRESS: 1811 Druid Hill Ave

FEB 21 1927

very important. See instructions on back of certificates.

... statement of OCCUPATION 18

Spec.—1-12-23—M&T—500 Bks.

E 19250

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19250

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Josephs Hosp

CITY OF BALTIMORE: (No. 8-17 Caroline ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles J. Byrne

(a) RESIDENCE NO. 821 N Broadway ST., WARD Balt. Md

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Katie L. Byrne

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 82 — Months: — — Days: — — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): Register of Wills

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Daniel Byrne

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Byrne

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mamie Montgomery (Address) 2715 Guilford Ave

15 FILED FEB 21 1927 C. HARRY JONES, M. D. Registrar Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 20 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 3 1926, to Feb. 20 1927, that I last saw h[illegible] alive on Feb 19 1927, and that death occurred, on the date stated above, at 5 40 am m.

The CAUSE OF DEATH* was as follows:

Carcinomatosis of Spine

Period (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & X-ray

(Signed) Clement R. Monroe M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: 2/22 1927

UNDERTAKER: Chas F. Moore & Son

ADDRESS: 1811 W. Mt Royal Ave

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19251 100-001 E 19251

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2570 Salem ST. 13-59 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Langrill

(a) RESIDENCE No. 2570 Salem ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 10 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 26, 1926

7 AGE — Years: — Months: 10 Days: 24 (23) If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER Henry Langrill

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER Anna McCormick

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Henry Langrill 2570 Saltend St.

15 Filed: B 2 T 1927 By: — Registrar

C. HAMPSON JONES, M. D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 18, 1927, to Feb 19, 1927, that I last saw h[illegible] alive on Feb 19, 1927, and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

From puerperal (duration) several days yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Fred B Jones, M. D.

, 19 (Address) 2516 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: 2/21 1927

20 UNDERTAKER: Chas F. Brandt Son 1180 W. Royal ave — ADDRESS

(Over) Very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19252

## CERTIFICATE OF DEATH.

E 19252

REGISTERED NO. 21-56

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 230 Woodland Ave ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME M. ALICE HAYDON

(a) RESIDENCE NO. 230 W. WOODLAND AVE ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| FEMALE | WHITE | WIDOW |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of JOHN A. HAYDON

6 DATE OF BIRTH (month, day, and year) JULY 6, 1852

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs or ....min. |
|---|---|---|---|---|
| | 74 | 7 | 14 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) FREDERICK MD.

PARENTS

10 NAME OF FATHER JAMES McSHERRY

11 BIRTHPLACE OF FATHER (city or town) (State or country) PENNSYLVANIA

12 MAIDEN NAME OF MOTHER ELIZA SPURRIER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ELKRIDGE LANDING, MD

14 Informant MRS. J. B. WELLS
(Address) 230 WOODLAND AVE

15 Filed 2 1927 19 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 20 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 1 1926 to Feb 20 1927, that I last saw her alive on Feb 19 1927, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Charles J. Wells, M. D.

, 19 (Address) 1242 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. John's Cemetery-Frederick MD

DATE OF BURIAL 2/22 1927

20 UNDERTAKER Henry W. Means & Son

ADDRESS 825 N Calvert St

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-002

E 19253

## CERTIFICATE OF DEATH.

E 19253

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 548 W. Preston St., 17-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Irene S. Costelles

(a) RESIDENCE NO. 548 W Preston St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | Colored | |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of child

6 DATE OF BIRTH (month, day, and year) April 10, 1926

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | | 10 | 8 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md.

PARENTS

10 NAME OF FATHER Charles Costelles

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Evelyn Stewart

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md

14 Informant Evelyn Stewart

(Address) 548 W. Preston St

15 Filed 1927 C. Hampton Jones M. D. Registrar

Per _____

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cap Bronchitis

(duration) yrs. 5 mos. 2 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

(Signed) J. C. Wade M. D.

(Coroner)

2-21-1927 (Address) 43 E Lorraine

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Lebanon Cemetery Date of Burial Feb 21, 1927

20 UNDERTAKER Mrs. Katie R. Williams ADDRESS 322 N. Schroeder St

very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19254

## CERTIFICATE OF DEATH.

E 19254

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1613 Mc Culloh St.; 14-20 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leona Roberts

(Residence in Baltimore: No. 1613 Mc Culloh St.; 1 yrs., 1 mos. 29 ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

| 3-SEX. | 4-COLOR OR RACE. | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) |
|---|---|---|
| Female | Col | Single |

6-DATE OF BIRTH, Dec. 20, 1925
(Month) (Day) (Year)

7-AGE, 1 yrs. 2 mos. 29 ds. If LESS than 1 day, ....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) ditto

9-BIRTHPLACE, (State or Country), Cumb. Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Bettie Roberts

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE ~~IS~~ TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) T. W. Davis

(Address) 1530 N. Carey

15-
Filed B 2 1927, 191.....
C. HAMPSON JONES, M. D.
Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 2 (Month) 19 (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 2-15-27 191..., to 2-18-27 191..., that I saw her alive on 2-19-27 191..., and that death occurred, on the date stated above, at 9.15 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) 6 yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Rachitis

(Duration) 0 yrs. 6 mos. ds.

(Signed) F. A. Caid M. D.

2-18-27 191... (Address) 1524 Mc Culloh

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

| 19-PLACE OF BURIAL OR REMOVAL. | DATE OF BURIAL. |
|---|---|
| Mt. Auburn | Feb. 21, 1927 |
| 20-UNDERTAKER Wm. H. Deaver Son | ADDRESS 420 Mosher |

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19255

## CERTIFICATE OF DEATH.

74-001

E 19255

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 517 E. 21st ST., 9-19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ann Coughlt

(a) RESIDENCE NO. 517 E. 21st ST., ... WARD ...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Female | White | widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Coughlt

6 DATE OF BIRTH (month, day, and year) ~~[illegible]~~

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 74 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Govans, Md.

PARENTS

10 NAME OF FATHER John Norton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mr. Connor (Address) 517 E. 21st

15 Filed 2 1 1927 19... C. HAMPSON JONES, M. D. Registrar Per ...

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18th 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 10th, 1926 to Feb 18th, 1927.

that I last saw her alive on Feb 18, 1927

and that death occurred, on the date stated above, at 9.20 P m.

The CAUSE OF DEATH* was as follows:

apoplexy - Hemiplegia

... (duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis - Old age

... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Reginald J. Tonry M. D.

, 19 (Address) 414 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Marys Govans — DATE OF BURIAL Feb ... 1927

20 UNDERTAKER Rula Wiedefeld — ADDRESS 917 Greenmt Ave

THIS IS VERY important—See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 19256

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19256

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1130 Homewood Ave Ward 10-14)

2-FULL NAME James P. Phillips

(a) RESIDENCE NO. 1130 Homewood Ave. Ward 10

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie E

6 DATE OF BIRTH (month, day, and year) unknown

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 68 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) City

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Hugh —

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER — Logan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/19 1927

17 I HEREBY CERTIFY, That I attended deceased from 10/26 1926 to 2/19 1927.

that I last saw h— alive on 2/19 1927.

and that death occurred, on the date stated above, at 7 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Gall Bladder

unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Bernard Lowe M. D.

Feb 20. 1927 (Address) 914 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

14 Informant Mrs Annie E Phillips (Address) 1130 Homewood Ave

15 Filed FEB 21 1927 C. HAMPSON JONES, M. D. Registrar

Per

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's Woods

DATE OF BURIAL Feb 23 1927

20 UNDERTAKER Rita Wiedefeld

ADDRESS 914 Gramm St

Spec.—1-12-23—M&T—500 Blks.

E 19257

# HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 19257

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1511 E. Crat St. 3-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Wertheimer

(a) RESIDENCE NO. 1511 E Crat St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? 53 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | W. | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harris Wolf Wertheimer

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 80 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work old age

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Harris Wolf Wertheimer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Sam Levin

(Address) 98 Hanover Court

15 Filed 2 1927, 19 Per C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/20 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov. 20, 1926, to May 20, 1927, that I last saw h[illegible] alive on May 20, 1927 and that death occurred, on the date stated above, at 8 P m

The CAUSE OF DEATH* was as follows:

Senile Marasmus

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary) myocardial insufficiency

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) 1810 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Hebrew Mark Rd | 5/21 1927 |

20 UNDERTAKER Jack Levin ADDRESS 1439 E Balt St

Spec.—1-12-23—M&T—500 Blks.

290366

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19258
1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

101-001

E 19258
REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPI ST., 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Victoria Jercyak

(a) RESIDENCE NO. 2026 Fleet ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | white | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 11, 1926

| 7 AGE Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|
| — | 7 | 9 | — |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Joe Jercyak.

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Martha Kowalski

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Maryland

14 Informant Records
(Address) JOHNS HOPKINS HOSPI

Filed FEB 21 1927 C. HAMPSON JONES, M.D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 20 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 18, 1927, to Feb. 20 1927, that I last saw h alive on Feb. 20 1927 and that death occurred, on the date stated above, at 4 30 A m

The CAUSE OF DEATH* was as follows:

pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. E. Handley, M.D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Feb | DATE OF BURIAL: 21 1927

20 UNDERTAKER: John McFeeley | ADDRESS: 1153 Hanover

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19259

## CERTIFICATE OF DEATH.

E 19259

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3708 Woodland ave ST., 15-65 WARD)

2-FULL NAME Mr. August Kline.

(a) RESIDENCE NO. 3708 Woodland ave ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Kline

6 DATE OF BIRTH (month, day and year) Sept 26-1855

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs. or ....min. |
|---|---|---|---|---|
| | 71 | 6 | 23 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) Retz & Klute

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER August Kline

11 BIRTHPLACE OF FATHER (City or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Lentzner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Schlegel
(Address) 3708 Woodland ave

15 Filed FEB 21 1927 C. HAMPSON JONES, M. D. Registrar
Per RK.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby. 14th 1927.

17 I HEREBY CERTIFY, That I attended deceased from Dec. 11th, 1926 to Feby. 14th, 1927.
that I last saw him alive on Feby. 14th, 1927.
and that death occurred, on the date stated above, at 12:05 A. m.

The CAUSE OF DEATH* was as follows: Acute Pulmonary Edema.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardia a mitral lesion, & arteriosclerosis. (duration) Several years.

18 Where was disease contracted if not at place of death? Not known.

Did an operation precede death? No Date of X

Was there an autopsy? no

What test confirmed diagnosis? Frothy bloody Sputum & C.

(Signed) O. H. Hoffman M. D.

2/19, 1927 (Address) 2500 Garrison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cem

DATE OF BURIAL 2/21, 1927

20 UNDERTAKER J. A. Moran

ADDRESS 306 E Baltimore

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19260

## CERTIFICATE OF DEATH.

90

E 19260
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1817 Madison Ave ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah J. Moore

(a) RESIDENCE No. 1817 Madison Ave ST.— WARD
(Usual place of abode)
Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Colored | Widowed |

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~(or)~~ WIFE of John H. Moore

6 DATE OF BIRTH (month, day, and year) June 7, 1834

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 42 | 8 | 10 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Cook 6d

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington DC

PARENTS

10 NAME OF FATHER Wm Holland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charles Co Md

12 MAIDEN NAME OF MOTHER Mary Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Prince Geo Co Md

14 Informant Mary E. Jones
(Address) 1817 Madison Ave

15 Filed 2-1 1927 19 C. HAMPSON JONES, M. D. Registrar
Per P.M.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 17. 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 11th. 1927. to Feb 21. 1927.
that I last saw h_r alive on Feb. 11th. 1927.
and that death occurred, on the date stated above, at 7:30 P. m.
The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Tobacco Syphilis
(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. Lee Chis. M. D.

2/18. 1927 (Address) 914 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: 2/21/27

UNDERTAKER: Thos P. G. Elliott — ADDRESS: 1727 Eutaw

Spec.–7-17-26–A Co.–200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19261 129 E 19261

## CERTIFICATE OF DEATH

E 19261

1-PLACE OF DEATH

REGISTERED NO. .....

City of BALTIMORE: (No. 34 N. Ellwood Ave. St. 6-11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Bender

(a) RESIDENCE NO. 34 N. Ellwood Ave St. ..... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S. if of foreign birth? ..... yrs. ..... mos. ..... ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married. |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marion E. Bender.

6 DATE OF BIRTH (month, day, and year) Oct 17-1883.

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|---|
| | 43 | 4 | 0 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sergeant 061

(b) General nature of industry, business, or establishment in which employed (or employer) Balto. Police Dept.

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER George Bender.

11 BIRTHPLACE OF FATHER (City or town) Balto.

(State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Hausman.

13 BIRTHPLACE OF MOTHER (city or town) Balto.

(State or country) Md.

14 Informant Marion E. Bender. (Wife)

(Address) 34 N. Ellwood Ave

15 Filed 2-21-1927 C. HAMPSON JONES M. D. Registrar

Per R.K.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 17-1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 15 1927, to Feb 17 1927,

that I last saw h alive on Feb 16 1927,

and that death occurred, on the data stated above, at 7.40 A. m.

The CAUSE OF DEATH* was as follows: Cerebro hemorrhage. Complete

(duration) ..... yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary) Primary Edema

(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted

if not at place of death? .....

Did an operation precede death? ..... Data of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) ..... M. D.

....., 19 (Address) .....

*State the Disease Causing Death, or in deaths from Violant Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cem. Feb. 21st 1927

20 UNDERTAKER Lilly and Zeiler ADDRESS 103 S. Mo[illegible]

Very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 19262

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19262

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 505 Bloom St. 14-2016 WARD)

REGISTERED NO. 161-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant y Oliver Elmira Taylor

(a) RESIDENCE NO. 505 Bloom St. WARD

(Usual place of abode)

(If not resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | C | S |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 14th 27

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | | | 1 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Bty

PARENTS

10 NAME OF FATHER Oliver Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Indies

12 MAIDEN NAME OF MOTHER Elmira Barnes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Indies

14 Informant Olivia Taylor (Address) 505 Bloom St

15 Filed 21 1927 19 C. HAMILTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 14, 1927, to Feb 19, 1927, that I last saw h— alive on Feb 19, 1927, and that death occurred, on the date stated above, at 1 30 m.

The CAUSE OF DEATH* was as follows:

Premature Birth

Born with Congenital Syphilis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Burk Mills, M. D.

Feb 21, 1927 (Address) 1129 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dr Gross

DATE OF BURIAL Feb 22 1927

UNDERTAKER Thomas E Wyatt

ADDRESS 1314 Druid Hill Ave

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19263

## CERTIFICATE OF DEATH.

90 E 19263

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 866 W Baltimore ST. 18-16 WARD)

2-FULL NAME George T. Linden

(a) RESIDENCE NO. 866 W Baltimore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 9 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie M Linden

6 DATE OF BIRTH (month, day, and year) May 4th 1859

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 67 | 9 | 15 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sheet Metal Worker

(b) General nature of industry, business, or establishment in which employed (or employer) Sheet Metal

(c) Name of employer Broks

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Herman Linden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Lattena

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Annie M. Linden (Address) 866 W Balto St

15 Filed FEB 21 1927 C. HAMPTON JONES, M. D. Registrar Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 1st 1926, to July 19th 1927.

that I last saw him alive on July 17th, 1927.

and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris (duration) — yrs. 3 mos 19 ds.

CONTRIBUTORY (Secondary) Aortic Insufficiency (duration) — yrs 3 mos. 19 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Edward E Mackenzie, M. D.

July 19, 1927 (Address) 1339 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL Feb 18 1927

20 UNDERTAKER Harry H. Witzke — ADDRESS 1534 W. Lombard St.

Spec.—12-23-21—E.B.R.S.—400 Bks.

# E 19264 HEALTH DEPARTMENT—CITY OF BALTIMORE E 19264

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 222 N Calhoun St., 19-27 Ward) Registered No. 74-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME May Thomas

(a) Residence No. 222 N Calhoun St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. 50 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Thomas

6-DATE OF BIRTH (month, day and year) June 16 1856

7-AGE. 70 yrs. 8 mos. 3 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Home Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Fredericksburg (State or Country), Va

PARENTS.

10-NAME OF FATHER, Archard Carson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER (city or town) Md (State or Country)

14- (Informant) Mrs Samuel Thomas (Address) 222 N. Calhoun St

15- C. HAMPSON JONES, M. D. Registrar.

Filed FEB 21 1927

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 19-1927

17- I HEREBY CERTIFY, That I attended deceased from Oct 1, 1926 to Feb 19 1927 that I last saw h[illegible] alive on Feb 19 1927 and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Arterio sclerosis

(Duration) 4 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Edwards Morgan M.D.

19 (Address) 1325 N Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park

DATE OF BURIAL. Feb 21 19 27

20-UNDERTAKER. Harry E. Witzke

ADDRESS 531 W Lombard St

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 19265

## CERTIFICATE OF DEATH

E 19265

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 132 Mosher St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Helen Slater

(a) RESIDENCE NO. 137 Mosher St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George W. Slater

6 DATE OF BIRTH (month, day, and year) Mar. 11, 1851

| 7 AGE | Years | Months | Days | IF LESS than 1 day ...hrs. or ...min.. |
|---|---|---|---|---|
| | 75 | 11 | 8 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va

(State or country)

PARENTS

10 NAME OF FATHER James C. Moore

11 BIRTHPLACE OF FATHER (City or town) Pittsburgh

(State or country) Pa

12 MAIDEN NAME OF MOTHER Sapphira Smith

13 BIRTHPLACE OF MOTHER (city or town) Pa.

(State or country)

14 Informant M. Helen Slater

(Address) 132 Mosher St.

15 Filed 2 1 1927 C. HARRISON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 9, 1927, to Feb. 19, 1927, that I last saw h w alive on Feb. 19, 1927, and that death occurred, on the date stated above, at 4:22 P m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia (

(duration) yrs. mos 10 ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) W Bowman Stood M. D.

2/19, 1927 (Address) 626 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Greenmount Cem. | Feb 22 1927 |

20 UNDERTAKER Wm Tuckerman Sons ADDRESS North & Pa

Very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19266

# CERTIFICATE OF DEATH.

E 19266

1-PLACE OF DEATH Mercy Hospital

City of BALTIMORE: (No. 633 S. Charles St. 22-30 Ward)

REGISTERED NO. 12

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes McComb.

(a) RESIDENCE NO. 426 S. Edna St. / 633 S. Charles st St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. — mos. ds. — How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George McCombe

6 DATE OF BIRTH (month, day, and year): May 17th 1894

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 32. | 9 | 2 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Scotland

PARENTS

10 NAME OF FATHER: Isaac McKenzie

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Scotland

12 MAIDEN NAME OF MOTHER: Elizabeth Simons

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Scotland

14 Informant: George McCombe

(Address) 633 S. Charles st

Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 14 1927

17

I HEREBY CERTIFY, That I attended deceased from August 16, 1926, to Feb 19, 1927

that I last saw her alive on Feb. 19, 1927

and that death occurred, on the date stated above, at 6.25 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E Motta M. D.

. 19 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. Date of Burial Feb 22nd 1927

20 UNDERTAKER: E. Sellmann Son ADDRESS 1039 Hanover

Very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19267.

E 19267

## CERTIFICATE OF DEATH.

REGISTERED NO. 2290

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1320 Colhoun St. 52 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary L. Banks

(a) RESIDENCE NO. 1320 Colhoun ST., ..... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F. | C. | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Arthur Banks

6 DATE OF BIRTH (month, day, and year) 1904

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or ..... min. |
|---|---|---|---|---|
| | 23. | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Maid

(b) General nature of industry, business, or establishment in which employed (or employer) Private

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Jno Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Ella Tyler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Frank Hatter

(Address) 2434 Guilford Ave.

15 Filed FEB 21 1927 C. HAMPSON JONES, M. D. Registrar

By —

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 20 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1926 to Feb 20th 1927.

that I last saw him alive on Feb 19th 1927.

and that death occurred, on the date stated above, at 6 A.M. m.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Unknown to me

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Examined

(Signed) H. Lee Ellis, M. D.

Feb 21, 1927 (Address) 524 Mass Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Irvington-Lancaster Co. Va

DATE OF BURIAL Feb 22 1927

20 UNDERTAKER Jesse H. Riddell

ADDRESS 436 N. Biddle St

Cor.—12-9-25—A Co.—200 Bks.

E 19268

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

181-001

E 19268

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. Gen. Hosp. St. 17-25 Ward)

2-FULL NAME Thos. Alexander

(a) RESIDENCE NO. 527 N. Eden St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | colored | widower |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) About 1867

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 60 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Unknown

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant N. W. Dietz, Colvin

(Address) Eleanor av

15 Filed ..... 19 .....

C. HAMPSON JONES, M. D.

Registrar

1927 FROM THE MORGUE.

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 19, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest

(Inquest, autopsy or inquiry.) find that said deceased came to h... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxiation by gas accidental. (Gas stove)

(duration) .....yrs. .....mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) J. T. Hemmeter M. D.

(Coroner)

Feb 15, 1927 (Address) 250 Hamburg Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL Date of Burial 19

20 UNDERTAKER ADDRESS

Commissioner of Health. FEB 21 1927

Very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19269 E 19269

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. City Hospital St. 76-37 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Lyons

(a) RESIDENCE NO. Dundalk ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| M | W | S |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1902

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 25 | | | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant
(Address)

Filed 1-1927, 192 C. HAMPSON JONES, M. D. Registrar

1086 Ref

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide
Gun Shot Wound-
(duration) yrs. mos ds.
CONTRIBUTORY Shide
(Secondary)
(duration) yrs. mos. ds.

(Signed) G. E. Blades, M. D.
Feb 18 1927 (Coroner)
(Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL DATE OF BURIAL 192

20 UNDERTAKER Commissioner Health, ADDRESS

THE MORGUE. FEB 22

Per A. E. RODDALL.

Spec.—1-12-23—M&T—500 Blks.

E 19270

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19270

## CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

CITY OF BALTIMORE: No. JOHNS HOPKINS HOSPITAL St. 3-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Boones

(a) RESIDENCE NO. 174 S. Broadway St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Black | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) [illegible]

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min |
|---|---|---|---|---|
| | | 2 | 27 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cato. Md.

PARENTS

10 NAME OF FATHER Chas Boones

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Mary Carrie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant Records JOHNS HOPKINS HOSPITAL

(Address)

15 Filed [illegible] 19 [illegible] Registrar

1061

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 17 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan 26, 1927 to Feb 17, 1927

that I last saw h[illegible]alive on Feb. 17, 1927

and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

~~Lobar Pneumonia~~

Syphilis of the liver

(duration) yrs 2 mos ds.

CONTRIBUTORY (Secondary) Otitis media

(duration) yrs mos. 2 ds.

18 Where was disease contracted if not at place of death? In utero

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? None.

(Signed) H. E. Handley, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL 19

20 UNDERTAKER ADDRESS

JOHNS HOPKINS HOSPITAL FEB 27 1927

Commissioner of Health;

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19271

E 19271

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. ____ Ward)

REGISTERED NO. ____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Bouldin

(a) RESIDENCE NO. 664 W. Fayette st. St. ____ Ward ____

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1876

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| 51 | 50 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of indnstry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ____

(State or country) Nevada

PARENTS

10 NAME OF FATHER John Bouldin

11 BIRTHPLACE OF FATHER (city or town) ____

(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Mary Madden

13 BIRTHPLACE OF MOTHER (city or town) ____

(State or country) Ireland

14 Informant Hospital Records

(Address)

15 1927 C. HAMPSON JONES, M. D.

Per ____ Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

February 19, 1927

17 I HEREBY CERTIFY, That I attended deceased from February 16, 19 27, to February 19, 19 27,

that I last saw h... in alive on February 19, 19 27,

and that death occurred, on the date stated above, at 11.30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Tuberculous Enteritis

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of ____

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. E. Gatlin, M. D.

2-21-27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

Date of Burial 2/22 1927

20 UNDERTAKER James A. Jones

ADDRESS 170 Park

Very Important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 19272

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19272

## CERTIFICATE OF DEATH.

76

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 654 E. 35th St. 9-47 WARD)

2-FULL NAME Elizabeth Crosby

(a) RESIDENCE NO. 654 E. 35th St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. 7 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Fem. | white | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Crosby

6 DATE OF BIRTH (month, day, and year) July 5-1878

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 48 | 7 | 14 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 037

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Henry Burkheimer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Kraft

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Peter Crosby (Address) 654 E. 35th St.

15 Filed 1 1927, 19 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 1927

17 I HEREBY CERTIFY, That I attended deceased from 2/6, 1927, to 2/19 27, 19, that I last saw h[illegible] alive on 2/19, 1927, and that death occurred, on the date stated above, 8.30 m.

The CAUSE OF DEATH* was as follows:

Pneumonia

15 yrs. C. 15 yrs.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cause

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Henry T. Crosby, M. D.

(Address) 1 Wyndhurst Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cemetery — DATE OF BURIAL Feb 23 27

20 UNDERTAKER F. A. Kelbaugh Son — ADDRESS 703 Hanover

Spec.—12-9-25—A Co—200 Bks.

E 19273

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 19273

1-PLACE OF DEATH Church Home Infirmary REGISTERED NO. 117

City of BALTIMORE: (No. ——— St., 6-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Charles Hendley

(a) RESIDENCE NO. 1216 K. St N. W. St. Washington D. C. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: May Hendley

6 DATE OF BIRTH (month, day, and year): 1852

7 AGE: Years 75; Months; Days; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country) Ohio

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Unknown

14 Informant: Church Home & Infirmary

(Address) Broadway & E. N. Y.

C. HAMPSON JONES, M. D.

Feb 15 1927 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

February 21st 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb 13th 1927, to Feb 21st 1927, that I last saw h[illegible] alive on Feb 21st 1927, and that death occurred, on the date stated above, at 5:10 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Failure due to Hypostatic Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Appendicitis acute with General peritonitis

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Feb 15, 1927

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R. Clark Grove, M. D.

, 19 (Address) Church Home & Infy.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Washington D. C. Date of Burial: Feb. 21 1927

20 UNDERTAKER: Henry W. Means & Son ADDRESS: 800 N. Calvert St

Key important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

(Pauline Sohlich)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19274

# CERTIFICATE OF DEATH.

E 19274

1-PLACE OF DEATH

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS St., 30-69 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pauline Sohlich

(a) RESIDENCE NO. 2607 W. Lanvale St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Theodore Sohlich

6 DATE OF BIRTH (month, day, and year): June 29th 1851

7 AGE: Years 75 | Months 7 | Days 22 25 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town)

(State or country): Germany

PARENTS

10 NAME OF FATHER: Fred Strunk

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Teresa Cornet

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: BALTIMORE CITY HOSPITALS

(Address)

Filed ... 19 ... Registrar

C. HAMPSON JONES, M. D.

Per ACB

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 21 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb. 9, 1927, to Feb. 21, 1927

that I last saw h[illegible] alive on Feb. 21, 1927

and that death occurred, on the date stated above, at 5.15 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic, terminal

Arteriosclerosis

Hypertension

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Symptoms

(Signed) C. Hampson Jones M. D.

(Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Date of Burial Feb 23rd 1927

20 UNDERTAKER: F. B. Wolfert ADDRESS: 1850 W. Balto St

Key important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19275 E 19275

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1143 N Fulton Ave Ward 90) REGISTERED NO.

2-FULL NAME Sarah E. Gon.

(a) RESIDENCE NO. 1143 N Fulton St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 9 1852

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 75 | — | 1 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ooo

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Ambrose Todd

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Maryland

12 MAIDEN NAME OF MOTHER: Sarah E Todd.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md

14 Informant: Mrs. J. Gore St

(Address): 466 Appleton St

15 Filed ....., 19 ..... Registrar

CHAMPE S. JONES, M. D.

1 1927

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 20 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquiry (Coroner, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Mitral Stenosis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo Clinton Pfeiffer M. D.

(Coroner)

2/27 (Address) 1143 N Fulton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ..... mos., ..... ds. In the State ..... yrs., ..... mos., ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cambridge Md Date of Burial: Feb 23 1927

20 UNDERTAKER: J B Hyppert ADDRESS: 180 W Balto St

Keep superintendent. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19276

## CERTIFICATE OF DEATH.

E 19276

1-PLACE OF DEATH

City of BALTIMORE: (No. Pratt & Bway St. 1-3 Ward) 188-003

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Tymanowicz

(a) RESIDENCE NO. 2114 E Pratt St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced (c) WIFE of Antoni

6 DATE OF BIRTH (month, day, and year) Aug 22 1878

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 48 | 5 | 27 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Work

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Poland

PARENTS

10 NAME OF FATHER Thomas ?

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER ? Baronowicz

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Antoni Tymanowicz

(Address) 2114 E Pratt St

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Feb 19 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH was as follows:

Auto Accident

Multiple Fractures & Shock (Duration) yrs. mos. ds.

Instant Instant

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) C. Hadge M. D.

(Coroner)

2/22/27 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem Date of Burial Feb 23 1927

20 UNDERTAKER Frederick V Bogucki ADDRESS 1430 Eastern

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19277.

## CERTIFICATE OF DEATH.

202 E 19277

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Monument Place St. 2-4 Ward)

2-FULL NAME Michael Barkauskas

(a) RESIDENCE NO. 723 S Broad St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Zalonski

6 DATE OF BIRTH (month, day, and year) about 46

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| about 46 | | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Poland

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Hospital Record

(Address)

15 1927 C. HAMPSON JONES, M. D.

By ARH Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-11 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Acute Edema of Lungs

Contributory (Secondary) Pneumonia (duration) 1 day yrs. mos. ds.

Contributory (Secondary) Tuberculosis of Lungs (duration) yrs. mos. ds.

(Signed) Samuel Snyder M. D.

(Coroner)

, 19 27 (Address) 3325 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Date of Burial Jan 22 1927

20 UNDERTAKER H. W. Gazewski ADDRESS 1930 Eastern

Very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 19278

E 19278

24-00

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1681 Dudley Ave St. 8-45 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thos. Isiah Forest

(a) RESIDENCE NO. 1681 Dudley Ave St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Laura E. Forest

6 DATE OF BIRTH (month, day, and year): May 10-1853

7 AGE: Years 73 Months 9 Days 10

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired 73

(b) General nature of industry, business, or establishment in which employed (or employer): B. & O. R. R. McClure

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country): Md

PARENTS

10 NAME OF FATHER: Francis A. Forest

11 BIRTHPLACE OF FATHER (City or town): Balto:

(State or country): Md

12 MAIDEN NAME OF MOTHER: Susan Fisher

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country): Md.

14 Informant: Laura E. Forest

(Address): 1681 Dudley Ave

15 Filed: C. HAMPSON JONES, M. D.

2 1 1927 Per: Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 20 1927

17 I HEREBY CERTIFY, That I attended deceased from Jany 3 1925 to Feb 20 1927

that I last saw h.. alive on Feb 19 1927

and that death occurred, on the date stated above, at 12 45 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Arteries Sclerosis

(duration) 1 yrs. mos. 0 ds.

CONTRIBUTORY (Secondary): Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jas L Hooper M. D.

(Address) 962 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — Date of Burial: Feb 23 1927

20 UNDERTAKER: H. A. Cook — ADDRESS: 507 Eastern

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 19279

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19279

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Franklin Square Hospital REGISTERED NO. 101

CITY OF BALTIMORE: (No.) 9 York St ST. (WARD) 22-6

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr John O Hara

(a) RESIDENCE NO. 40 6 York St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W. | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 1890

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 37 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) Genetal nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer Any one

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Thomas O'Hara

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mayo

12 MAIDEN NAME OF MOTHER Mary McCordell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mrs Wmfield Fitzsimons (Address) New York City N Y

15 Filed FEB 21 1927 By C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 19 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb 16 1927 to Feb 19 1927

that I last saw him alive on Feb 19 1927

and that death occurred, on the date stated above, at 10 30 a m.

The CAUSE OF DEATH* was as follows:

Bilateral Pneumonia

(Over)

3 days (duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) W Wallace Walker M. D.

19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer — DATE OF BURIAL Feb 22 1927

UNDERTAKER J M Cook — ADDRESS 507 E Fleet St

Spec.—1-12-23—M&T—500 Bks.

29 9
2 E 19280

# HEALTH DEPARTMENT—CITY OF BALTIMORE E 19280

## CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. JOHNS HOPKINS HOSPITAL ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hudson Trout

(a) RESIDENCE NO. Davidsonia P.O. ST. Cumberland Co. Pa.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widowed |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1856

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min |
|---|---|---|---|---|
| | 71 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Michael Trout

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa -

12 MAIDEN NAME OF MOTHER E Connor Hickman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa -

14 Informant Records —
(Address) JOHNS HOPKINS HOSPITAL

15 Filed FEB 1 1927 C. HAMPSON JONES, M. D. Registrar
Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 7- 1927, to Feb 26 1927, that I last saw him alive on Feb 26 1927 and that death occurred, on the date stated above, at 1.05 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate
Br. Pneumonia
Myocardial Failure

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Syphilis; Obesity

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of Feb 16 '27

Was there an autopsy? No

What test confirmed diagnosis? Laboratory tests

(Signed) R.W. Schacht, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Hanestown. Pa | 1/31 1927 |
| 20 UNDERTAKER C. D. Barton | Md. Northern Parkway |

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19281

## CERTIFICATE OF DEATH.

49 E 19281

1-PLACE OF DEATH

City of BALTIMORE: (No. 1429 William St. St. 24-33 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elmore A. Norris.

(a) RESIDENCE NO. 1429 William St. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male. | White. | Widower. |

5a If ~~XXXXXX~~ widowed, ~~XXXXXXXX~~ HUSBAND of (~~XXXXXXXX~~) Mary Norris.

6 DATE OF BIRTH (month, day, and year) July 19, 1854.

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 72 | 7 | 0 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work B. & O. R. R. Engineer.

(b) General nature of industry, business, or establishment in which employed (or employer) R.R. 073

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) Washington Co. Md.

PARENTS

10 NAME OF FATHER William Norris.

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Do not know.

14 Informant Harry S. Norris. (son)

(Address) 1429 William St.

15 1927 C. HAMPSON JONES, M. D. Registrar

Per A.C.J.

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 19, 1927. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma of the bladder. (Con)
Myocardial Insufficiency.
Acute dilatation of the heart.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Leinhardt M. D. (Coroner)

2/21 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?_____

Former or usual residence_____

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Mt. Olivet Cem | Feb 22. 27 |
| 20 UNDERTAKER Margaret A. Flynn | ADDRESS 1422 Light |

Very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 19282

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19282

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Franklin Square Hospital 101

CITY OF BALTIMORE: (No. 21-29 ST. WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James T. Leonard

(a) RESIDENCE No. 855 Washington Blvd ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 23rd 1881

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 46 | 0 | 26 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ironworker.

(b) General nature of industry, business, or establishment in which employed (or employer) Ost

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER James Leonard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant John J. Leonard. (Address) 855 Wash. Blvd.

15 Filed 2 1 1927 16 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Feby 18, 1927, to Feby 18, 1927, that I last saw him alive on 2-18, 1927, and that death occurred, on the date stated above, at 9½ P m.

The CAUSE OF DEATH* was as follows:

Pleurisy with effusion

2/17/27 (duration) yrs mos ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation (duration) yrs mos ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical Sign.

(Signed) W W Walker M. D.

, 19 (Address) Franklin Sq Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters Cemetery DATE OF BURIAL Feby 22nd 1927

20 UNDERTAKER Margaret D. Flynn ADDRESS 1422 Light

Spec.—1-12-23—M&T—500 Bks.

E 19283

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19283

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memonal Hosp ST. 12 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriet A Derby

(a) RESIDENCE NO. Goverrnment Hotel Bldg R-I ST. ..... WARD .....

(Usual place of abode) Washington D.C.

(If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Femak | W White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 26 1862

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or .... min. |
|---|---|---|---|---|
| | 64 | 9 10 | 25 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Typist

(b) General nature of industry, business, or establishment in which employed (or employer) U.S. Goverrmeni

(c) Name of employer Washington D.C

9 BIRTHPLACE (city or town) (State or country) Alabama

PARENTS

10 NAME OF FATHER Chas H Derby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Charlotte Bassett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mrs T. F Shaw

(Address) 821 Beaumont Av Balto

15 FILED ..... 19 ..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 21 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 4 1922, to Feb 21 1927, that I last saw her alive on Feb 21 1927, and that death occurred, on the date stated above, at 1-28 P m.

The CAUSE OF DEATH* was as follows:

Coronary thrombosis

(duration) — yrs. — mos 3 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Lewis Allo Taylor M. D.

19 (Address) Union Memonal Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Onancock Va

DATE OF BURIAL 2/22/1927

20 UNDERTAKER Harry A Wilkins

ADDRESS 531 W Lenton

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 19284

E 19284

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 2405 E. Federal St St. 8-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joshua M. Bull

(a) RESIDENCE NO. 2405 E. Federal St St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cora G.Bull

6 DATE OF BIRTH (month, day, and year) May 8/1868

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 58 | 9 | 12 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Penna R.R.

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Joshua Bull

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Eliza Schenk

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Cora G. Bull

(Address) 2405 E. Federal St

15 Filed 2/21 1927 HAMPSON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 20/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

(Valvular Insufficiency)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. S. Collins M. D. (Coroner)

2/21/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery Date of Burial 2/23 1927

20 UNDERTAKER William Cook ADDRESS 502 E North Ave

Very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19285

## CERTIFICATE OF DEATH.

E 19285

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 418 W Mulberry St., (WARD) 7-25

2-FULL NAME John J Bryan

(a) RESIDENCE NO. 418 W Mulberry St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie C Bryan

6 DATE OF BIRTH (month, day, and year): June 1, 1871

7 AGE: Years 55 Months 8 Days 19 If LESS than 1 day, hrs. or min. 20

8 OCCUPATION OF DECEASED:

(a) Trade, profession or particular kind of work: Gold Gilder

(b) General nature of industry, business, or establishment in which employed (or employer): Jew

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Edw Bryan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Annie C Bryan

(Address) 418 W Mulberry

FEB 2 1927

Filed Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feby 24 1927

17 I HEREBY CERTIFY, That I attended deceased from about Feby 24 1927, to Feby 24 1927,

that I last saw h alive on Feby 24 1927,

and that death occurred, on the date stated above, at 10:30 a m.

The CAUSE OF DEATH* was as follows:

acute heart attack (Syncope)

(duration) few minutes (Syncope) yrs. mos ds.

CONTRIBUTORY (Secondary) hypocardity

(duration) several years yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas E Simons, M. D.

Feby 25, 1927 (Address) 5 E. Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem

DATE OF BURIAL: Feby 28 27

20 UNDERTAKER: George A Farley

ADDRESS: Fulton Fayette

Spec.—1-10-21—M&T—1500 Bks.

E 19286

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

10 001. E 19286

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 129 N Wolfe ST. 6-9 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Flora Matthews.

(a) RESIDENCE NO. 129 N Wolfe ST., ..... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | White | Married. |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James I Matthews.

6 DATE OF BIRTH (month, day, and year) Mar 16 1890

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 36 | 11 | 6 4 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER George Eason

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Mary Godden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant James Matthews (Address) 129 N Wolfe St

15 Filed Feb 22 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 20 1927

17 I HEREBY CERTIFY, That I attended deceased from February 14, 1927, to February 19, 1927.

that I last saw her alive on February 19, 1927,

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. . mos 8 ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank J. Ayd M. D.

Feb 21, 1927 (Address) 2005 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wade North Carolina

DATE OF BURIAL Feby 23 1927

20 UNDERTAKER John Ulrich

ADDRESS 2 E Preston

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 19287 (1-PLACE OF DEATH)

74-201

E 19287 REGISTERED NO.

City of BALTIMORE: (No.) 210 W Hamburg St. (Ward) 23rd

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Savoy

(a) RESIDENCE NO. 210 W Hamburg St. Ward 23rd

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm Savoy

6 DATE OF BIRTH (month, day, and year): 1865

7 AGE: Years 60 Months Days

IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Cook

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Basil Savoy

11 BIRTHPLACE OF FATHER (City or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Helen Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Viola Payne

(Address) 210 W. Hamburg St

15 Filed ..... 19 ..... Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/21/ 19 27

17 I HEREBY CERTIFY, That I attended deceased from Feb 19 27, to Feb 21 19 27

that I last saw h alive on Feb 20 19 27

and that death occurred, on the date stated above, at 7:30 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 1 yrs. mos. da.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 2 mos. da.

18 Where was disease contracted no

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

2/24/1927 (Address) 708 Druid Pk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — Date of Burial 2-24 1927

20 UNDERTAKER: John H. Frazier — ADDRESS 1127 Druid Hill

FEB 22 1927 C. HARRY JONES, M.D.

Very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 19288
1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

REGISTERED NO. E 19288

City of BALTIMORE: (No. 537 W. Cross St. 21-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Priscilla Wallace

(a) RESIDENCE NO. 537 W. Cross St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. 7 mos. 1 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Fe | Colored | single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) (?) 1863

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| abt | 64 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Calvert Co. Md

PARENTS

10 NAME OF FATHER (?)

11 BIRTHPLACE OF FATHER (city or town)

(State or country) (?)

12 MAIDEN NAME OF MOTHER (?)

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) (?)

14 Informant Ella Bradley

(Address) 537 W Cross St

FEB 22 1927 C. HAMPSON JONES, M.D. Registrar

Filed ..... 19..... Per ..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 19th 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 15 1927, to Feb 19 1927, that I last saw h[illegible] alive on Feb 19 1927, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Senile debility

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Dr K Arnold, M. D.

2/24/1927 (Address) 801 Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — Date of Burial 2-22 1927

20 UNDERTAKER John H. Toadvine — ADDRESS 1027 Druid Hill

Key important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19289

## CERTIFICATE OF DEATH.

101-001

02-29

E 19289

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 507 N. Cross St. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter Wilson Jr.(C)

(a) RESIDENCE NO. 507 N. Cross St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 8 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male. | Colored | Single. |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) June 17, 1926.

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 0 | 8 | 8 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 0

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Walter Wilson, Sr. (C)

11 BIRTHPLACE OF FATHER (city or town)

(State or country) South Carolina.

12 MAIDEN NAME OF MOTHER Lilly Pettice. (C)

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) North Carolina.

14 Informant Lilly Wilson. (C) mother.

(Address) 507 N. Cross St.

15 Filed ..... 19 ..... Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 20, 1927. 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

(duration) .....yrs. .....mos. .....ds.

(Signed) Otto Reinhardt M. D.
(Coroner)

2/21 1927 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death .....yrs., .....mos., .....ds. In the State .....yrs., .....mos., .....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Dr. W. Carlson Gen Feb 22/27

20 UNDERTAKER ADDRESS

Daniel Easton 916 Dean.

Very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

# E 19290 HEALTH DEPARTMENT—CITY OF BALTIMORE

100-014

## CERTIFICATE OF DEATH.

E 19290

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 615 Wilkes Ct ST. 17-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irene Smith

(a) RESIDENCE NO. 615 Wilkes Ct ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | colored | single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 13 1926

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | | 11 | 10 | 8 |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore City

(State or country) "

PARENTS

10 NAME OF FATHER Peter Smith

11 BIRTHPLACE OF FATHER (city or town) md

(State or country)

12 MAIDEN NAME OF MOTHER Irene Smith

13 BIRTHPLACE OF MOTHER (city or town) Va

(State or country)

14 Informant Irene Smith

(Address) 615 Wilkes Court.

15 Filed ....., 19 C. HARRISON JONES, M. D. Registrar

FEB 22 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 21 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 17, 1927, to Feb 21, 1927, that I last saw her alive on Feb 21, 1927, and that death occurred, on the date stated above, at 3.40 p m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Primary) (duration) yrs. mos 14 ds.

CONTRIBUTORY

(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ....

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) H. K. Cooley, M. D.

, 19 (Address) 1600 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL Feb 23/27

20 UNDERTAKER Dana Eastern ADDRESS 76

Spec.—12-9-25—A Co.—200 Bks.

E 19291

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

100-001

E 19291

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 848 Vine St. 18-2½ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Otho Wilson

(a) RESIDENCE NO. 848 Vine St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | Colored | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 26/924

| 7 AGE Years | Months | Days 25 | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|
| 2 | 2 | 26 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Otho Wilson

(Address) 848 Vine

15 Filed 2-27-1927 C. HAMILTON JONES, Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 21 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 16, 1927, to Feb 21, 1927, that I last saw h..... alive on Feb 20, 1927, and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Pulm. Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

Feb. 27, 1927 (Address) 1629 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Date of Burial Feb 22 1927

20 UNDERTAKER Daniel Easton ADDRESS 916 Eager.

Key, Instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 19292 HEALTH DEPARTMENT—CITY OF BALTIMORE E 19292

CERTIFICATE OF DEATH.

1-PLACE OF DEATH ~~2032 Etting~~ St

CITY OF BALTIMORE: (No. 2032 Etting ST., 14-70 WARD) REGISTERED NO. 132

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vincent Green

(a) RESIDENCE NO. 2032 Etting ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | Married |

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Lavinia Green

6 DATE OF BIRTH (month, day, and year) August ~~September~~ 1853

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min |
|---|---|---|---|---|
| about 74? | 73 | 6 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butler 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mr. Dillon Detroit 104 E. Biddle St

9 BIRTHPLACE (city or town) (State or country) Centreville Md

PARENTS

10 NAME OF FATHER Christopher Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Susan Hunt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Lavinia Green (Address) 2032 Etting St. Feb 22 1927

15 [illegible] HARRY JONES, M. D. Registrar

FEB 22 1927

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 20th 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 7th, 1927, to Feb 20th, 1927, that I last saw her alive on Feb 14th, 1927, and that death occurred, on the date stated above, at 12.10 A m.

The CAUSE OF DEATH* was as follows:

acute pyelitis following stone in Bladder

(duration) yrs. mos 18 ds.

CONTRIBUTORY (Secondary) Chronic Sclerosis

(duration) 15 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? X-ray disclosed Bladder Stone

(Signed) M. A. Debey, M. D.

Feb 20th, 1927 (Address) Preston Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem

DATE OF BURIAL 2/22/1927

UNDERTAKER Samuel J. Wimsley

ADDRESS 78 N Biddle

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19293

## CERTIFICATE OF DEATH.

90

E 19293
REGISTERED NO.

1-PLACE OF DEATH
City of BALTIMORE: (No.) 213 S Dallas St. 3-rd Ward)

2-FULL NAME Elsworth Cooper

(a) RESIDENCE NO. 213 S- Dallas St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Usual place of abode)
Length of residence in city or town where death occurred 20 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | Col. | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) . 1867

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 60 | — | — | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Washington
(State or country) D.C.

PARENTS

10 NAME OF FATHER Thomas Cooper
11 BIRTHPLACE OF FATHER (city or town)
(State or country) Washington D.C.
12 MAIDEN NAME OF MOTHER Sarah Mulington
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Washington D.C.

14 Informant Sophie Travis
(Address) 32 S. Caroline St

15 Filed ....., 19.. HARRY M. JONES, M. D.
2-2 1927 Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 19 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Mitral Stenosis

(duration) yrs. mos. ds.
CONTRIBUTORY Exhaustion
(Secondary)
(duration) yrs. mos. ds.

Feb 21 1927 (Signed) H. Blades M. D.
(Coroner)
(Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery Date of Burial Feb 22 1927

20 UNDERTAKER Jos. T. A. Lochester ADDRESS 1403 Hoffman St

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

38 E 19294

E 19294

1-PLACE OF DEATH

REGISTERED NO._____

City of BALTIMORE: (No. 211N. Monfford Ave St. 610 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eugene Carr/ Kier

(a) RESIDENCE NO. 211 N. Montford Ave St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | col | single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of XXXXXX

6 DATE OF BIRTH (month, day, and year) 1877

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 50 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER John Carr

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Hester Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Josephine Kier

(Address) 1527 Orleans St

15 Filed FEB 22 1927 C. HAMPSON JONES, M. D.

Per _____ Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 20/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Aortic Anuerism or Embolis

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Syphillis

(duration) .....yrs. .....mos. .....ds.

(Signed) Joseph H Carter M. D.

(Coroner)

2/21/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Albert cemetery Date of Burial Feb 23 1927

20 UNDERTAKER Edward Bryan ADDRESS 1681 orleans st

Very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

2E 370
2E 19295

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-0.01
100 E 19295

## CERTIFICATE OF DEATH.

6-9

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., WARD)

2-FULL NAME Arlton Batten

(a) RESIDENCE NO. 138 N. Bond St -ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | — |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) aug 21. 1926

| 7 AGE Years | Months | Days | If LESS than 1 day, hrs or min |
|---|---|---|---|
| | 6 mos. | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md -

PARENTS

10 NAME OF FATHER Centie Batten

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va -

12 MAIDEN NAME OF MOTHER Gladys Edwards

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va -

14 Informant Recndo -
(Address) JOHNS HOPKINS HOSPITAL

15 Filed 2 2 1927. 19 C. HAMPSON JONES, M. D.
Registrar
By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 21 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 18 . 1927 . to Feb 21 . 1927 .
that I last saw him alive on Feb 21 . 1927
and that death occurred, on the date stated above, at 4 30 P. m
The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 9 ds.

CONTRIBUTORY —
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore
Did an operation precede death? No Date of —
Was there an autopsy? Yes
What test confirmed diagnosis? —
(Signed) N. E. Handley, M. D.
, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Leakin cemetery — DATE OF BURIAL: Feb 23 1927

20 UNDERTAKER: Edward Bryon — ADDRESS: 1631 orleans st

Spec.—1-12-23—M&T—500 Bks.

25-228

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19296

## CERTIFICATE OF DEATH.

100-001 Ded

E 19296

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPIT (St.) 3-4 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Botts -

(a) RESIDENCE NO. 1109 S Bond ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred / yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | |

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1852.

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 71. | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va -

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va -

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va -

14 Informant Records -

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 2 2 1927, 19 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 19 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb 14, 1927, to Feb 19, 1927,

that I last saw h~~im~~live on Feb 19, 1927

and that death occurred, on the date stated above, at 12 30 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia -

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) H. E. Handley, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury cemetery

DATE OF BURIAL Feb 22 1927

UNDERTAKER Edward Bryan

ADDRESS 168 Orleans st

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19297

## CERTIFICATE OF DEATH

49

E 19297

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. 16-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emil a. Schultze

(a) RESIDENCE NO. 1203 W Mulberry St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ida Schultze

6 DATE OF BIRTH (month, day, and year): May 23. 1860

7 AGE: Years 66 Months 8 Days 28

IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): Custom House

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country): Md

PARENTS

10 NAME OF FATHER: August Schultze

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Amelia Fischer

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: Pauline Mayer

(Address): 1203 W. Mulberry St

15 Filed ....., 19.... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927

Feb 20

17 I HEREBY CERTIFY, That I attended deceased from Feb 18, 1927, to Feb 20, 1927,

that I last saw him alive on Feb 20, 1927,

and that death occurred, on the date stated above, at 4:40 P m.

The CAUSE OF DEATH* was as follows:

Uraemia - pyo nephrosis

Indefinite (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) See remarks in reference made

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted

If not at place of death? unknown see remarks on back

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. S. Anderson, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — Date of Burial: Feb 23 1927

20 UNDERTAKER: Mrs & Mrs John W. Teufel & Son — ADDRESS: 801 W. Fayette

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19298

## CERTIFICATE OF DEATH

X100 391

E 19298

1-PLACE OF DEATH University Hospital

REGISTERED NO.

City of BALTIMORE: (No. Lombard & Greene St., (Ward) 4-30 (Kirwan)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Kinman

(a) RESIDENCE NO. Hull England St. (Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 9 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown 1888

7 AGE: 38 39 Years Months Days IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Seaman

(b) General nature of industry, business, or establishment in which employed (or employer): S.S. Glenlum

(c) Name of employer

9 BIRTHPLACE (city or town): Hull

(State or country) England

PARENTS

10 NAME OF FATHER Thomas Kinman.

11 BIRTHPLACE OF FATHER (City or town)

(State or country) England

12 MAIDEN NAME OF MOTHER Minnie Johnson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) England

14 Informant University Hospital Records

(Address) Lombard & Greene Sts.

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

FEB 27 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Feb. 21, 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 2, 19 26, to Feb 2, 19 27

that I last saw him alive on Feb 2, 19 27

and that death occurred, on the date stated above, at 2.45 P.M.

The CAUSE OF DEATH* was as follows:

Broncho - Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchial Asthma

(duration) yrs. 3 mos. ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Evidence

(Signed) I. A. Peacock M. D.

2-21 19 27 (Address) Emergency Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemetery

Date of Burial: Feb. 22 19 27

UNDERTAKER Harold B Cook

ADDRESS 1008 W. Baltimore St

Very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19299

## CERTIFICATE OF DEATH.

100-001

E 19299

1-PLACE OF DEATH Union Memorial Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3300 Coleman ST. 12-44 WARD)

2-FULL NAME Mrs George A. Miller

(a) RESIDENCE No. 112 Putty Hill Road ST. Fullerton Md WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs George A. Miller

6 DATE OF BIRTH (month, day, and year) Sept. 13th 1872

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 54 | 5 | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Produce Commission

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Mogdt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant S. Katherine Miller

(Address) Fullerton Md

15 Filed FEB 22 1927 C. HARRY JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 19 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb 17, 1927, to Feb 19, 1927,

that I last saw h— alive on Feb 19, 1927

and that death occurred, on the date stated above, at 2:11 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Fullerton Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edwin Carlton Wareham, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. John's Lutheran

DATE OF BURIAL Feb 23 1927

20 UNDERTAKER Fred'k Lassahn & Sons

ADDRESS Fullerton

Spec.—1-10-21—M&T—1500 Bks.

E 19300

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19300

## CERTIFICATE OF DEATH.

Raykeburg

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Radecke Ave near Franklin Ave ST. 76 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Radecke

(a) RESIDENCE NO. Radecke Ave. near Franklin ave ST. WARD Raykeburg

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Philip Radecke

6 DATE OF BIRTH (month, day, and year) Sept 30 1852

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 74 | 4 | 20 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Co.

(State or country) Md

PARENTS

10 NAME OF FATHER Wm H. Lutz

11 BIRTHPLACE OF FATHER (city or town) Balto Co.

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Diefenbach

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs. R. Radecke

(Address) Raykeburg Md

Filed FEB 22 1927 C. HAMPSON JONES, M.D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 20 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb 1, 1927, to Feb 20, 1927,

that I last saw h alive on Feb 20, 1927,

and that death occurred, on the date stated above, at 9.55 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis

(Signed) Claud Hunt M.D.

1927 (Address) 4706 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Jerusalem Lutheran

DATE OF BURIAL Feb 24 1927

20 UNDERTAKER Fred K. Leasner Sons

ADDRESS Fullerton

Spec.—1-12-23—M&T—500 Blks.

E 19301 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 19301
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph Hospital (ST.) 4-17 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfred E. Kent

(a) RESIDENCE NO. Chase Md ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mildred M. Kent

6 DATE OF BIRTH (month, day, and year): Oct. 29th 1883

7 AGE — Years: 43 | Months: 3 | Days: 24 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Clergyman Minister
(b) General nature of Industry, business, or establishment in which employed (or employer): M.E. Church
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Cornwall England

PARENTS

10 NAME OF FATHER: Richard J. Kent

11 BIRTHPLACE OF FATHER (city or town) (State or country): Cornwall England

12 MAIDEN NAME OF MOTHER: Ellen Jenkin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Cornwall England

14 Informant: Mildred M. Kent
(Address): Chase Md.

15 Filed 2/28 1927 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 22 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 18 1927 to Febr 22 1927 that I last saw him alive on Febr 22 1927 and that death occurred, on the date stated above, at 2.45 A.M.

The CAUSE OF DEATH* was as follows:

Septicemia (Cancer)

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Clement R. Woodall, M. D.

2/28, 1927 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery — DATE OF BURIAL: Feb. 25 1927

20 UNDERTAKER: Fredk Lassahn & Son — ADDRESS: Fullerton

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19302

## CERTIFICATE OF DEATH.

122-002

REGISTERED NO. E 19302

1-PLACE OF DEATH

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS St. 41-5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Martin

(a) RESIDENCE NO. 619 N. Calvert St. Sycamount Ave. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) May 10/1854

| 7 AGE | Years | Months | Days | If LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 72 73 | 9 | 9 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Car cleaner

(b) General nature of industry, business, or establishment in which employed (or employer) 073

(c) Name of employer

9 BIRTHPLACE (city or town) ?

(State or country) Virginia

PARENTS

10 NAME OF FATHER Wm. Martin

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia.

12 MAIDEN NAME OF MOTHER Ann (?)

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant BALTIMORE CITY HOSPITALS

(Address)

FEB 22 1927

Filed C. HAMPSON JONES, M. D. Registrar

Per RH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 16, 1926, to Dec 19, 1927

that I last saw h.. alive on Dec 19, 1927

and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of liver

(Primary or antecedent)

(duration) yrs. 4 mos. da.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General & Symptoms

(Signed) C. Hampson Jones M. D.

(Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet Date of Burial Feb 22 1927

20 UNDERTAKER George J. South ADDRESS 1532 Hollins

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19303

## CERTIFICATE OF DEATH

15 E 19303

REGISTERED NO.

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. Calvert & 33rd Street ST.) 19-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Frank Onion, Aged Men's Home,

(a) RESIDENCE No. 1400 West Lexington ST., WARD City.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 31, 1857

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 69 | 1 | 21 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Onion

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown Onion

12 MAIDEN NAME OF MOTHER Francis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mary E. Forstal (Address) 1400 W. Lexington St

15 Filed FEB 22 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 21, 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 15, 1927, to Feb. 21, 1927, that I last saw h inmalive on Feb. 21, 1927, and that death occurred, on the date stated above, at 10 50 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Broncho.)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 2-16-27

Amputation 2nd toe for Senile Gangrene.

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Irvine McHenry M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Mount Olivet | Feb 23 1927 |
| 20 UNDERTAKER George J. Smith | ADDRESS 1532 Hollins |

Spec.—1-12-23—M&T—500 Bks.

VAN SANT ✓

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19304

## CERTIFICATE OF DEATH.

90

E 19304

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Greenway Apartments St. 12-49 WARD)

2-FULL NAME George Frank Van Sant

(a) RESIDENCE NO. Greenway Apartments ST., 12 WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 9 mos. 10 ds. How long in U. S., if of foreign birth? 61 yrs. 9 mos. 10 ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Van Sant

6 DATE OF BIRTH (month, day, and year) May-11-1865

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 61 | 9 | 10 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER John E. Van Sant

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Johanna Maher

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Ireland

14 Informant Mary E. Van Sant (wife)

(Address) Greenway Apartments

15 Filed ... 19 ... C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb-21-1927

17

I HEREBY CERTIFY, That I attended deceased from Dec 20, 1926, to Feb 21, 1927, that I last saw him alive on Feb 20, 1927, and that death occurred, on the date stated above, at 5.45 p. m.

The CAUSE OF DEATH* was as follows:

Myocarditis. Aortitis arteriosclerosis

(duration) yrs. 4 mos — ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Julius Friedenwald, M. D.

Feb 19 27 (Address) 1013 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| New Cathedral Cemetery | Feb 23-27 19 |

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19305

## CERTIFICATE OF DEATH.

E 19305

REGISTERED NO.

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. Calbert & 33rd Sts. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Max G. F. Neuber

(a) RESIDENCE No. La Gerna, Cuba ST., WARD Cuba.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred about yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married. |

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Mrs Max G. F. Neuber

6 DATE OF BIRTH (month, day, and year) April 19, 1863

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 63 | 10 | 11 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of Industry, business, or establishment in which employed (or employer) Farming

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Ferdinand Neuber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Augusta Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Josephine Gonzalez Neuber (wife)
(Address) 4408 Spruce St. Phila. Pa.

Filed FEB 22 1927 C. HAMPSON JONES, M.D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 21, 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 15, 1927, to Feb. 21, 1927, that I last saw him alive on Feb. 21, 1927, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach.

Asthma. (duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial failure. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of Feb. 21, 1927

Was there an autopsy? No

What test confirmed diagnosis? Gastro-enterostomy, Jejunal

(Signed) Louis Edelstein M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Phila. Pa. DATE OF BURIAL. Feb 22 / 1927

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor) ADDRESS 108 W. NORTH AVE.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19306

## CERTIFICATE OF DEATH.

31

E 19306

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 506 E. Eager ST. 10-15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William J. O'Neill

(a) RESIDENCE No. 506 E. Eager ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Jan 10 1890

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 37 | 1 | 10 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work General Labor

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Hugh O'Neill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth Hyan

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Richard O'Neill (Address) 506 E Eager St

15 Filed FEB 22 1927 Registrar

Date

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 20 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb. 18, 1927, to Feb 20 1927, that I last saw h alive on alive on Feb 19 1927 and that death occurred, on the date stated above, at 11 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary ~~tub~~ Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Pulmonary T B.

(duration) yrs. mos. ds.

18 Where was disease contracted if ~~not~~ at place of death? Yes

Did an operation precede death? ~~Date~~ Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical History

(Signed) James M Fenton, M. D.

2-22 1927 (Address) 706 Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 2/24 1927

20 UNDERTAKER Elmer W. Coulbourn

ADDRESS 224 E. Eager St.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19307

## CERTIFICATE OF DEATH.

89 E 19307

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2823 Riggs Ave St. 1668 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph John Back

(a) RESIDENCE NO. 2823 Riggs Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | married |

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary S. Back

6 DATE OF BIRTH (month, day, and year) 8-10-1860

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 66 | 6 | 10 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Adam Back.

11 BIRTHPLACE OF FATHER (city or town) Wurttemburg

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Dorothea Jacob.

13 BIRTHPLACE OF MOTHER (city or town) ?

(State or country) Germany.

14 Informant Mary S. Back.

(Address) 2823 Riggs ave.

15 Filed FEB 22 1927 C. HAMILTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-20-1927.

17 I HEREBY CERTIFY, That I attended deceased from 2-1-1924, to 2-20-1927, that I last saw him alive on 2-15-1927, and that death occurred, on the date stated above, at 10:30 a m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) 12 yrs. — mos. — ds.

CONTRIBUTORY none
(Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs.

(Signed) Chester Eyland, M. D.

2-20, 1927 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial New Cathedral Cemetery Feb 23 1927

20 UNDERTAKER Robt J Turner ADDRESS 467 N. Broadway

Very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

E 19308

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 E 19308

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 820 N Ensor St. 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Ward

(a) RESIDENCE NO. 820 N Ensor St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: C

5 Single, Married, Widowed, or Divorced. (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Pinkie Ward

6 DATE OF BIRTH (month, day, and year): Feb 1 1878

7 AGE — Years: 49 — Months: 0 — Days: 14 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Atlantic Co

PARENTS

10 NAME OF FATHER: William Ward

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Ga

12 MAIDEN NAME OF MOTHER: Annie Bennett

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Ga

14 Informant: Ada Sutton

(Address): 820 N. Ensor St

15 Filed FEB 22 1927 C. HAMPSON JONES, M. D. Registrar

Per RM

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 18 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb 15 1927, to Feb 18 1927, that I last saw him alive on Feb 18 1927, and that death occurred, on the date stated above, at 8:20 P m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) ____

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? no mark

Did an operation precede death? ____ Date of ____

Was there an autopsy? no

What test confirmed diagnosis? Phthisis

(Signed) Gobtelen, M. D.

2-22, 1927 (Address) 508 Somerset

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial: Mt. Auburn Cemetery 2/22/27

20 UNDERTAKER: Mrs. P. A. Elliott — ADDRESS: 1725 Ashland av.

Very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Stillborn.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19309

## CERTIFICATE OF DEATH.

6-10 101-001

E 19309 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 517 N. Milton ave ST., 6-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mabel B. Stilton

(a) RESIDENCE NO. 517 N. Milton ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 4 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, ~~Married, Widowed or Divorced~~, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 3rd 1876

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 50 | 4 | 18 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) 068

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER William Stilton

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Theresa Lowry

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Frank V. Coggins
(Address) 19 S. Charles St

15 Filed B 2 2 1927 C. HAMPSON JONES, M. D.
By R.K. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 21st 1927

17 I HEREBY CERTIFY, That I attended deceased from Feby 18th 27 to Feby 21st 27.
that I last saw her alive on Feby 21st 19 27
and that death occurred, on the date stated above, at 10:45 a.m.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Asthenia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. Lowe M. D.

(Address) 1501 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Baltimore Cemetery | Feby 23rd 1927 |

20 UNDERTAKER George Schilling & Sons ADDRESS 1126 E Monument St

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19310

## CERTIFICATE OF DEATH.

49 E 19310

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 602 Lennox St. 13-59 Ward)

2-FULL NAME Roberta Davis

(a) RESIDENCE NO. 602 Lennox ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 1843

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 83 | 7 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired teacher

(b) General nature of industry, business, or establishment in which employed (or employer) 666

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Robert Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Caroline McConkey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant James McConkey Sister
(Address) 1108 Bolton St.

15 Filed FEB 22 1927 C. HAMPSON JONES, M. D. Registrar

By K M

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 19, 1927

17 I HEREBY CERTIFY, That I attended deceased from June, 19 26, to Feb 19, 1927, that I last saw h-er alive on Feb 19, 1927, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cancer of Bladder

(duration) 2 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) coma

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Microscopic

(Signed) W R Lee, M. D.

2/21, 1927 (Address) 836 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. DATE OF BURIAL: Feb. 22, 1927

UNDERTAKER: John C. Mitchell ADDRESS: 1900 Eutaw Place

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19311

## CERTIFICATE OF DEATH.

E 19311
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3913 Liberty Heights ave STS. 1564 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard S. Young

(a) RESIDENCE No. 3913 Liberty Heights ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (Write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie H. Young

6 DATE OF BIRTH (month, day, and year) Mch 25 1847

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 79 | 10 | 27 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Jersey

PARENTS

10 NAME OF FATHER Joseph F. Young

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.J.

12 MAIDEN NAME OF MOTHER Harriet Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.Y.

14 Informant Carrie B. Gault

(Address) 3913 Liberty Heights Ave

15 FILED FEB 22 1927 CHARLES S. WILLIAMS, M. D. COMMISSIONER OF HEALTH

By

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 21 1927

17

I HEREBY CERTIFY, That I attended deceased from Dec 22, 1926, to Feby 21, 1927, that I last saw h[illegible] alive on Feby 20, 1927, and that death occurred, on the date stated above, at 12.15 p m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. ? mos ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) yrs. ? mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? Clinical symptoms

(Signed) William E. Todd, M. D.

, 19 (Address) 1111 Washington

*State the Disease Causing Death, or in deaths from Violent Means, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bloomsbury N.J. DATE OF BURIAL July 24 1927

UNDERTAKER Louis O. Mitchell ADDRESS 1900 Eutaw Place

Spec.—1-12-23—M&T—500 Blks.

# E 19312 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 19312

REGISTERED NO. 57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSP. St. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susanna Michael

(a) RESIDENCE No. Winona Apartments ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 28, 1854

7 AGE — Years: 72 Months: 5 Days: 24 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Edwin Michael

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland U.S.A.

12 MAIDEN NAME OF MOTHER: Martha Street

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland U.S.A.

14 Informant (Address)

Filed 2-2-1927 C. HAMPSON JONES, M. D. Registrar

By R.R.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 21 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 11, 1927, to Feb 21, 1927, that I last saw h alive on Feb 21, 1927 and that death occurred, on the date stated above, at 5.55 p. m.

The CAUSE OF DEATH* was as follows:

~~Gangrene of foot~~ Diabetes mellitus

(duration) 3 yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) ~~Diabetes mellitus~~ Gangrene of foot. (duration) 3 yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 2/17/27

Was there an autopsy? No

What test confirmed diagnosis? Blood chemistry for diabetes.

(Signed) R. Glenn Craig, M. D.

, 19 (Address) Johns Hopkins Hosp. Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL: Greenlawn Cem. Harford Co.

DATE OF BURIAL: Feb 24 1927

UNDERTAKER: Wm. J. Tuckner & Sons

ADDRESS: North E

Spec.—I-10-21—M&T—1500 Bks.

Olea Geza

E 19313

# HEALTH DEPARTMENT—CITY OF BALTIMORE

99-001

E 19313.

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church St Road Brooklyn Out Bay REGISTERED NO.

CITY OF BALTIMORE: (No. 15-75 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Olga Geza

(a) RESIDENCE NO. Church St Road ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 16 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 1925

7 AGE — Years: 1 — Months: 4 — Days: — If LESS than 1 day, ..... hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Peter Geza

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Julia Igar

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Peter Geza (Address) Church St Rd Out Bay

15 Filed 3 2 1927 C. HAMPSON JONES, M. D. Registrar

Rec'

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 21 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 21, 1927, to Feb 21, 1927, that I last saw h— alive on Feb 21, 1927, and that death occurred, on the date stated above, at 3-30 P m.

The CAUSE OF DEATH* was as follows: Convulsions

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Dentition Bronchitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas O'Brooke, M. D.

, 1927 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cem. DATE OF BURIAL: Feb 23- 1927

20 UNDERTAKER: Jacob Dalkowski ADDRESS: 458 S. Bond

How to fill out this certificate is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 19314 — 129 — E 19314

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 841 S. Bond St. St. 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ludwik P. Boroba

(a) RESIDENCE NO. 841 S. Bond St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. 0 mos. 0 ds. How long in U. S. If of foreign birth 35 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Helena Boroba

6 DATE OF BIRTH (month, day, and year) Not Known

| 7 AGE | Years | Months | Days | IF LESS than 1 day ... hrs. or ... min.. |
|---|---|---|---|---|
| | 63 | 0 | 0 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker 088

(b) General nature of industry, business, or establishment in which employed (or employer) -

(c) Name of employer -

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Peter Boroba

11 BIRTHPLACE OF FATHER (City or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Tekla Bialowacka

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Poland

14 Informant Helena Boroba (wife)

(Address) 941 S. Bond St

Filed FEB 22 1927

C. HAMILTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/20 1927

17 I HEREBY CERTIFY, That I attended deceased from 2/6, 1927, to 2/20, 1927,

that I last saw h~~is~~ alive on 2/19, 1927,

and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, (Chronic)

Dyspnea Dysphagia

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Duct fracture & Broncho Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Ida A Burbeck, M. D.

2/22, 1927 (Address) 1607 E Baltimore

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary — Date of Burial 2/24 1927

UNDERTAKER Fiaskowski — ADDRESS 1618 Eastern Ave

Very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19315

1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

11-001

E 19315

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 518 W. Lee ST. 22-30 WARD)

2-FULL NAME Edward Jackson

(a) RESIDENCE NO. 518 W. Lee ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Col | Married |

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Hattie Jackson

6 DATE OF BIRTH (month, day, and year) ? 1896

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 31 | ? | ? | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) S. C.

PARENTS

10 NAME OF FATHER John Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C.

12 MAIDEN NAME OF MOTHER Minnie Crawford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. C.

14 Informant Hattie Jackson

(Address) 518 W. Lee St

15 Filed 2-23-1927 HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/22/1927

17 I HEREBY CERTIFY, That I attended deceased from 2/17, 1927, to 2/22, 1927, that I last saw h[illegible] alive on 2/22, 1927, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of -

Was there an autopsy? no

What test confirmed diagnosis? -

(Signed) D. T. Carroll, M. D.

2/23, 1927 (Address) 805 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL [illegible] OR REMOVAL [illegible] Chester St. B. C. DATE OF BURIAL Feb 23 1927

20 UNDERTAKER David Easton ADDRESS 916 Eutaw St.

Almira Taylor

# HEALTH DEPARTMENT--CITY OF BALTIMORE

E 19316 — PLACE OF DEATH

## CERTIFICATE OF DEATH

129 — E 19316 — REGISTERED NO. C

CITY OF BALTIMORE (No. 8 South Pulaski St) 2069 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Almira Taylor

(Residence in Baltimore: No. 8 South Pulaski St.) 73 yrs. mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS

| 3-SEX | 4-COLOR OR RACE | 5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word) |
|---|---|---|
| female | white | widow |

6-DATE OF BIRTH: October (Month) 28, (Day) 1853 (Year)

7-AGE: 73 yrs. 3 mos. 24 ds. | If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Maryland

PARENTS

10-NAME OF FATHER: David Drelan

11-BIRTHPLACE OF FATHER (State or country): New Jersey

12-MAIDEN NAME OF MOTHER: Rachel Booker

13-BIRTHPLACE OF MOTHER (State or country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. A. H. Greenfield

(Address) 88 S. Pulaski

15 — Date FEB 23 1927, 191 — C. HAMPSON JONES, M. D. — REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Feb (Month) 22 (Day), 1927 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 8, 1927, to Feb 22 1927, that I saw h[illegible] alive on Feb 21, 1927, and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Uremia Coma

(Duration) yrs. mos. 17 ds

Contributory (SECONDARY) Chronic nephritis

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Feb 22, 1927 (Address) Catonsville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

| | At place of death | In the State |
|---|---|---|
| | yrs. mos. ds. | yrs. mos. ds. |
| Where was disease contracted, if not at place of death? Former or usual residence | | |

19-PLACE OF BURIAL OR REMOVAL: Western Cemetery — DATE OF BURIAL: Feb. 24, 1927

20-UNDERTAKER: Wm. J. Tuckwell Sons N. & Pa. — ADDRESS

IS VERY IMPORTANT. See instructions on back of certificate. Exact statement of OCCUPATION

Cor.—12-9-25—A Co.—200 Bks.

# È 19317

## HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

È 19317

### CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2648 Boone St St. 9-50 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alice Elliott

(a) RESIDENCE NO. 2648 Boone St St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

#### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | col | single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 11/26

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 0 | 9 | 10 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Richard Elliott

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Hanover Co., Va.

12 MAIDEN NAME OF MOTHER Adda Burke

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Middlesex Co., Va.

14 Informant Adda Burke

(Address) 264 Boone St

15 Filed FEB 23 1927 C. HAMPTON JONES, M. D. Registrar

#### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 21/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (Primary)

(duration) .....yrs. .....mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) J. H. Callen M. D.
(Coroner)

2/22/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem Date of Burial Feb 23 1927

UNDERTAKER David Carter ADDRESS 916 Park Ave.

Very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

Ê 19318

## CERTIFICATE OF DEATH.

150 Ê 19318

1-PLACE OF DEATH Women's Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. John + Lafayette St. 9 1-2 WARD)

2-FULL NAME Mary Rogers Wolfe

(a) RESIDENCE NO. 4302 Ronwood Road ST., Guilford WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Henry Wolfe

6 DATE OF BIRTH (month, day, and year): March 1, 1893

| 7 AGE | Years | Months | Days | If LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 33 | 11 | 19 18 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Rockford, Ill.

PARENTS

10 NAME OF FATHER: James Rogers

11 BIRTHPLACE OF FATHER (city or town) (State or country): Scotland

12 MAIDEN NAME OF MOTHER: Ada Collison

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Rockford Illinois.

14 Informant: John Henry Wolfe

(Address): 4302 Ronwood Rd.

15 FILED FEB 23 1927 19 C. HAMPSON JONES, M. D. Registrar

By RK

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 19, 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 17, 1927, to Feb. 19, 1927, that I last saw her alive on Feb. 19, 1927, and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Toxemia myocardial degeneration.

(duration) yrs. few hours mos. ds.

CONTRIBUTORY (Secondary) Puerperal mastitis, septicemia, femoral phlebitis (staph aureus) (duration) — yrs. — mos. 2½ ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Feb 4, 1927

Was there an autopsy? No!

What test confirmed diagnosis? Blood Culture, Abscess culture

(Signed) Frederick Henry Krouse, M. D.

, 19 (Address) Woman's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem

DATE OF BURIAL: Feb 25 1927

20 UNDERTAKER: Leary & Kuntzen Sons Co

ADDRESS: Mulberry & Cathedral Sts

TION is very important See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

È 19319

## CERTIFICATE OF DEATH.

È 19319

1-PLACE OF DEATH

City of BALTIMORE: (No. 1113 Bruce St. 21-31 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Everetta Cook

(a) RESIDENCE NO. 1113 Bruce St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Col | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 8 1926

| 7 AGE Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|
| 1 | — | 12 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) —

(State or country) Baltimore

PARENTS

10 NAME OF FATHER James Wells

11 BIRTHPLACE OF FATHER (city or town) —

(State or country) Md

12 MAIDEN NAME OF MOTHER Edmonia Cook

13 BIRTHPLACE OF MOTHER (city or town) —

(State or country) Baltimore

14 Informant Edmonia Cook

(Address) 1113 Bruce

15 Filed_____, 19____ _____ Registrar

FEB 23 1927 C. HAMPSON JONES, M. D.

By _____

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 27

Feb 20

17

I HEREBY CERTIFY, That I attended deceased from Feb 12, 19 27, to Feb 20, 19 27, that I last saw h.. alive on Feb 19, 19 27, and that death occurred, on the date stated above, at 5.30 A.M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

Following Acute Bronchitis

(duration) ....yrs. ....mos. 8 ds.

CONTRIBUTORY —

(Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) D. Harold, M. D.

(Address) 805 Thames

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Mt Auburn | Feb 23 19 27 |

| 20 UNDERTAKER | ADDRESS |
|---|---|
| Wm. H. Chase & Son | 400 Madison |

Very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

# È 19320 HEALTH DEPARTMENT—CITY OF BALTIMORE È 19320

## CERTIFICATE OF DEATH.

11-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1107 Harlem Ave (St.) 16-26 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie R. Easterfield

(a) RESIDENCE. No. 1107 Harlem Ave St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divoreed
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 7 26

7 AGE — Years: 1 — Months: — Days: 15 — If LESS than 1 day, ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Lee Easterfield

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant Lee Easterfield
(Address) 1107 Harlem Ave

15 Filed FEB 23 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 17, 1927, to Feb 22, 1927, that I last saw h[illegible] alive on Feb 22, 1927, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Influenza

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thos. Woolridge, M. D.

2-27 1927 (Address) 703 W Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: Feb 25 1927

20 UNDERTAKER: Fred W Crase Jr — ADDRESS: 140 N Mason

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

Ē 19321 Ē 19321

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1129. St Paul St S.E. Cor. Pratt St Ward 1927 129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha Phillipps

(a) RESIDENCE NO. 324 N. Eutaw St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 3-85

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 41 | 5 | 18 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balt (State or country): Md

PARENTS

10 NAME OF FATHER: B Phillipps

11 BIRTHPLACE OF FATHER (city or town): Balt (State or country):

12 MAIDEN NAME OF MOTHER: Ella Garner

13 BIRTHPLACE OF MOTHER (city or town): Balt (State or country): Eden Mills

14 Informant: Ella Phillipps

(Address): 324 N. Eutaw

Filed: 2 3 1927 C. HAWLEY JONES, M. D. Registrar

Per RK

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 21 27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 2 yrs. mos. ds.

(Signed) W J Phelps M. D.

(Coroner)

, 19 27 Address) 1079 Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Date of Burial: Feb 24 1927

*20 UNDERTAKER: Jane W Cease Sons ADDRESS: 1400 Madison

Very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 19322 — 31 — E 19322

1-PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE, (No.) 1619 Abbott (St.) 7-13 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Kelleher

(a) RESIDENCE No. 1619 Abbott ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Black | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cora Killian

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs. or ....min. |
|---|---|---|---|---|
| | 54 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER John Killian

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Katerina Brat

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Katherine Killian

(Address) 1619 Abbott St.

Filed 2-3-1927 C. HAMPSON JONES, M. D. Registrar

Ref

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 20 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 1 1924 to Feb 20 1927.

that I last saw h... alive on Feb 19 1927

and that death occurred, on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH* was as follows:

Pul. Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Laryngeal Tuberculosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum

(Signed) [illegible] M. D.

(Address) 606 N Dallas St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Feb 24 1927

20 UNDERTAKER Frank Crocker — ADDRESS 1906½ Eden St

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE.

E 19323

## CERTIFICATE OF DEATH.

90 E 19323

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 1108 Ward) 21-29 St., ____ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Andrew V. Ferguson

(a) RESIDENCE NO. 1108 Ward St. ____ Ward ____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widower |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Feb 9 1872

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 55 | 11 | | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Not employed
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town).....
(State or country) Balto -

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town).....
(State or country) Unknown

14 Informant A. V. Ferguson
(Address) 1108 Ward St.

15 Filed 2 23 1927 C. HAMPSON JONES M. D.
Registrar
Pat

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Feb 20, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (or post-mortem or inquiry.) thereon and from the evidence obtained by said Inquest (or post-mortem or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Mitral Insufficiency
Fatal Dead
(Duration) ___ mos. ___ ds.
CONTRIBUTORY (Secondary) Chronic Rheumatism
(Duration) 2 yrs. ___ mos. ___ ds.

Feb 20 1927 (Signed) Thos. B. Horton M. D.
(Coroner)
(Address) Curtis Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Loudon Park Cemetery | 2/23/1927 |
| **20 UNDERTAKER** | **ADDRESS** |
| H. E. Lowman & Son | 901 Hollins St. |

very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

È 19324

## CERTIFICATE OF DEATH.

90

È 19324

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 806 N. Broadway St. 6-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph S. Tydings

(a) RESIDENCE NO 806 N. Broadway St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jane R. Tydings

6 DATE OF BIRTH (month, day, and year) Sept. 4-1853

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 73 | 5 | 15 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER John W. Tydings

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Martha A. Thomas

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Albert M. Tydings

(Address) 806 N. Broadway

15 Filed ... 19... C. HAMPSON GIBBONS Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 21 1927

17 I HEREBY CERTIFY, That I attended deceased from ... 1926, to Feby 21, 1927, that I last saw him alive on Feby 21, 1927, and that death occurred, on the date stated above, at 10.45a m.

The CAUSE OF DEATH* was as follows:

Chronic Heart Disease

(duration) 2 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Alfred Tyler, M. D.

Feb. 22, 1927 (Address) 704 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cem. Date of Burial Feb. 24 1927

20 UNDERTAKER Wm. E. Blade ADDRESS 927 N. Broadway

Why important. See instructions on back of certificates.

B 23 1927

Rec

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19325

## CERTIFICATE OF DEATH.

101-001

E 19325

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 231 N Ann ST., 2-4 (WARD)

2-FULL NAME Ernst Sommers

(a) RESIDENCE NO. 231 N Ann ST., 1 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Catherine E. Sommers

6 DATE OF BIRTH (month, day, and year): March 1, 1847

7 AGE — Years: 77 — Months: 11 — Days: 9 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Bricklayer

(b) General nature of Industry, business, or establishment in which employed (or employer): Building House all

(c) Name of employer: work Retired

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: John Sommers

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Elysabeth Kraft

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Catherine Sommers (Address) 231 N Ann

15 FEB 23 1927 C. HAMILTON JONES, M. D. Registrar

Per [illegible]

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 20 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 19, 1927, to Feb 20, 1927, that I last saw h[illegible]ive on Feb 20, 1927, and that death occurred, on the date stated above, at 11 [illegible] m.

The CAUSE OF DEATH* was as follows:

Lobo Pneumonia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary): Nil

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. F. Long M. D.

2/21, 1927 (Address) 4701 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem. DATE OF BURIAL: Feb. 23 1927

UNDERTAKER: Mrs. Albert E. Fuller ADDRESS: 4804 Harford Rd.

SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.–7-17-26—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

19326

## CERTIFICATE OF DEATH

x 49 ✓

REGISTERED No. E 19326

1-PLACE OF DEATH University Hospital

City of BALTIMORE: (No. 4-30 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur K. Easter.

(a) RESIDENCE NO. Easton, Md. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) ? ? 1857

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 70 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hotel Proprietor

(b) General nature of industry, business, or establishment in which employed (or employer) Hotel

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER John Easter

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Shayley

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Hospital Records.

(Address)

15 Filed FEB 23 1927 C. Hampson Jones, M. D. Registrar

Per K.H.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/22/27 19

17 I HEREBY CERTIFY, That I attended deceased from 2/19/27, 19 to 2/22/27, 19

that I last saw him alive on 2/22/27, 19

and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

Part Operative Shock

(duration) yrs. mos. one ds.

CONTRIBUTORY Carcinoma of Head of Pancreas causing Obstruction to the Duodenum

(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted? Symptoms of three months duration

If not at place of death?

Did an operation precede death? yes Date of 2/17/27

Was there an autopsy? For intestinal obstruction

What test confirmed diagnosis? Autopsy

(Signed) J. S. Winstead, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Easton. Md. Date of Burial Feb. 25 1927

20 UNDERTAKER Harry H Welzke ADDRESS 1331 Homland Ave

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

9 Kaupas

# HEALTH DEPARTMENT—CITY OF BALTIMORE

71-001

Ê 19327

## CERTIFICATE OF DEATH.

Ê 19327

1-PLACE OF DEATH Franklin Square Hospital. REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Fayette & Calhoun Sts. WARD 16-1/2)

2-FULL NAME Mr Pete Kaupas

(a) RESIDENCE NO. 14 Fremont Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 25. 1902

7 AGE 24 Years 5 Months 26 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... Labar

(b) General nature of industry, business, or establishment in which employed (or employer) No.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Geo. Kaupas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithvania

12 MAIDEN NAME OF MOTHER Julee Velkavicite

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithvania

14 Informant Julee Kaupas (Address) 14 Tremont Row

15 Filed 2 3 1927 C. HAMPSON JONES, M. D. Registrar Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/21/27

17 I HEREBY CERTIFY, That I attended deceased from 2/1/27, 19 . to 2/21/27, 19 , that I last saw him alive on 2/21/27, 19 , and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Meningetis

2/1/27 (duration) 2/21/27 1 mos ds.

CONTRIBUTORY (Secondary) Cellulitis Left arm

(duration) 2/17/27 2 wks. 2/21/27

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 2/17/27

Was there an autopsy? No

What test confirmed diagnosis? Spinal Puncture

(Signed) W. Wallace Walker M. D.

, 19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Holy Redeemer | Feb. 24. 1927 19 |

20 UNDERTAKER John Grebliauckas ADDRESS 423 S Paca St

E.G.

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19328 E 19328

## CERTIFICATE OF DEATH.

90

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1392 N. Northern St. 13 59 WARD)

2-FULL NAME Mrs. Sophie Whitehouse

(a) RESIDENCE NO. 1392 N. Northern St. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | W | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Whitehouse

6 DATE OF BIRTH (month, day, and year) Nov 1 1857

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min |
|---|---|---|---|---|
| | 69 | 3 | 21 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Elkanah Linger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant L. S. Whitehouse
(Address) 1392 Eutaw Place

Filed B 2-3 1927 C. Hamilton Jones M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 21, 1924, to Feb 22, 1927, that I last saw h[illegible] alive on Feb 22, 1927 and that death occurred, on the date stated above, at 3 P M

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency.
Arteriosclerosis.
Hypertension
(Symptoms) (duration) 2 yrs. 4 mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Paul H. Clough M. D.

, 19 (Address) 24 E. Eager St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Herrer Friedhof Co. DATE OF BURIAL: 1927

UNDERTAKER: Jack Lewis ADDRESS: 1439 E. Baltimore St

Spec.—1-12-23—M&T—500 Bks.

19329

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

+100 E 19329

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 619 W Conway ST 2230 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.) U. G.

2-FULL NAME Bail Anderson

(a) RESIDENCE No. 619 W Conway ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Col | single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 28 yrs | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) S C

PARENTS

10 NAME OF FATHER Unknown Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) S C

12 MAIDEN NAME OF MOTHER Susie Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S C

14 Informant Mary Jones (Address) 619 W Conway St

15 Filed FEB 23 1927 HAMPTON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 19 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb. 18 1927 to Feb. 19 1927 that I last saw him alive on Feb. 19 1927 and that death occurred, on the date stated above, at 12.10 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) D. W. Kinnard M. D.

2-20 1927 (Address) 708 Union Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cemetery

DATE OF BURIAL 2 24 1927

20 UNDERTAKER Thos Gross H Hooper

ADDRESS 606 W Conway St

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

**E 19330** 90 **E 19330**

1-PLACE OF DEATH

City of BALTIMORE: (No. 2900 Brannan St.) 15-63 Ward

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Lavenia Coles

(a) RESIDENCE NO. 2900 Brannan St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ed R. Coles

6 DATE OF BIRTH (month, day, and year): 4/7/853

7 AGE — Years: 73 | Months: 8 | Days: 13 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Va

PARENTS

10 NAME OF FATHER: P B Burgess

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Va.

12 MAIDEN NAME OF MOTHER: Mary Coles

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Va

14 Informant: Mrs Lola Coles

(Address): 2900 Brannan

15 Filed ..... 19 ..... Registrar

B 23 1927 Per HARRY JONES M. D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 20 1927

17 I HEREBY CERTIFY, That I attended deceased from July 15 1927 to July 20 1927, that I last saw h.. alive on July 20 1927, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Valvular heart disease (Mitral incompetence)

(duration) 2 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary): not known

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Va.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Chas. T. Mellen M. D.

7/22 1927 (Address) 222 W. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Keswick Va.

Date of Burial: 7/23 1927

20 UNDERTAKER: J. Pitts Sons

ADDRESS: 1317 Eight

Very Important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

JACKSON

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19331

## CERTIFICATE OF DEATH.

31 ✓ E 19331

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. 21-29 E. B. W. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Jackson

(a) RESIDENCE NO. 819 W Ostend st. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | Colored | Widower |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1884

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| 43 42 | | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Georgia

PARENTS

10 NAME OF FATHER George Jackson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Georgia

12 MAIDEN NAME OF MOTHER Georgia Roberts

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Georgia

14 Informant Hospital Records

(Address)

15 Date 3-1-1927 16 C. HAWLEY JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 February 18, 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov. 10 19 26, to Feb. 18 19 27,

that I last saw him alive on Feb. 18 19 27,

and that death occurred, on the date stated above, at 11.20 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tbc

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Bacteriology

(Signed) W. E. Gallup M. D.

2-18-27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Date of Burial Feb 27 19 27

20 UNDERTAKER A. L. Brownson ADDRESS 108 Mott

very important. See instructions on back of certificates.

# HEALTH DEPARTMENT--CITY OF BALTIMORE

E 19332

## CERTIFICATE OF DEATH

11-001 E 19332

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 20 N. Castle St. St.: 6-9 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME George Schmitt

(Residence in Baltimore: No. 20 N. Castle St St.: yrs. 10 mos. 22 ds.)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word) |
|---|---|---|
| male | white | Single |

6 DATE OF BIRTH: March (Month) 24 (Day), 1926 (Year)

7 AGE: 27 yrs. 10 mos. 22 ds. If LESS than 1 day, ..... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): NO

9 BIRTHPLACE (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Joseph Schmitt

11 BIRTHPLACE OF FATHER (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Lillian Kaptain

13 BIRTHPLACE OF MOTHER (State or country): Baltimore Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph Schmitt

(Address) 20 N Castle St

15 FEB 23 1927 C. HAMPSON JONES, M. D. 191

REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: February (Month) 21 (Day), 1927 (Year)

17. I HEREBY CERTIFY, That I attended deceased from February 20, 1927, to, February 21 1927, that I saw h im alive on February 21, 1927, and that death occurred, on the date stated above, at 8 30 P. m.

The CAUSE OF DEATH* was as follows:

Infantile La Grippe

(Duration) yrs. mos. 10 ds

Contributory (SECONDARY) Broncho Pneumonia

(Duration) yrs. mos. 4 ds.

(Signed) Frank J. Ayd M. D.

Feb. 21, 1927 (Address) 2005 E. Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Feb 23, 1927

20 UNDERTAKER: Kendell Dysplaston — ADDRESS: 37 Amity

E IS VERY IMPORTANT. See instructions on back of certificate. Exact statement of OCCUPATION

E 19333

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 19333

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No.) 1354 W. 41 St (Ward) 13-57 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah E. Easton

(Residence in Baltimore: No.) 1354 W. 41 St

St.; yrs. 25 mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH: May (Month) 28 (Day), 1847 (Year)

7-AGE: 69 yrs. 8 mos. 24 ds. If LESS than 1 day, ....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or Country): Howard Co. Md

PARENTS.

10-NAME OF FATHER: Samuel Lusby

11-BIRTHPLACE OF FATHER (State or Country): Washington D.C

12-MAIDEN NAME OF MOTHER: Morganna Chaney

13-BIRTHPLACE OF MOTHER (State or Country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mr William T. Easton
(Address) 1354 W. 41 St

15-

Filed Feb 23 1927 C. HAMILTON JONES, M. D.
Registrar.
Per RH

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Feb. (Month) 22 (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ....no.... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ....no.... (Inquest, autopsy or inquiry.) ....no.... find that said deceased came to ....her.... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of Heart

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Thos H. Mossner (Coroner.) M. D.

2/25, 1927 (Address) 3532 Roland ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Lorraine Cemetery DATE OF BURIAL: Feb 25, 1927

UNDERTAKER: A. L. Marshall ADDRESS: 3539 Fall Road

Spec.-7-17-26—A Co.—200 Bks.

E 19334

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-08

E 19334

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 2220 Eutaw Place. St. 13-59 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Lauchheimer Hable

(a) RESIDENCE NO. 2220 Eutaw Place. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Hable

6 DATE OF BIRTH (month, day, and year) May 18th. 1855.

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min.. |
|---|---|---|---|---|
| | 71 | 9 | 3 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.

(State or country)

PARENTS

10 NAME OF FATHER Myer H. Lauchheimer

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Babette Eichberg.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany.

14 Informant Mr. Harold Hable

(Address) 2220 Eutaw Place.

15 Filed FEB 23 1927, 19 E. HAMPSON JONES, M. D. Registrar

Per RJK

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby. 21. 1927

17 I HEREBY CERTIFY, That I attended deceased from —, 1912, to Feby 21st, 1927, that I last saw h[e] alive on Feby 21st, 1927, and that death occurred, on the date stated above, at 8 45 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia - lobar

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) Dermatitis exfoliativa

(duration) — yrs. 2 mos. — ds.

18 Where was disease contracted —

if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Louis P. Hamburger, M. D.

, 19 (Address) 1207 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Oheb Shalom Cemetery | 2/23/ 1927 |

20 UNDERTAKER Harry Sondheim ADDRESS 118-20 W. Mt. Royal Ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19335

## CERTIFICATE OF DEATH.

101-001

E 19335

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital St. 10-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Oscar Douglas

(a) RESIDENCE NO. 1404 Anthony St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | col | married |

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Ruth Douglas

6 DATE OF BIRTH (month, day, and year) July 20/1897

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 29 | 7 | 0 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Coal Dealer

(c) Name of employer Oranda Coal Co

9 BIRTHPLACE (city or town)

(State or country) Richmond, Va

PARENTS

10 NAME OF FATHER Charles Douglas

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Richmond Va.

12 MAIDEN NAME OF MOTHER Mary Edwards

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Richmond Va

14 Informant Ruth Douglas

(Address) 1404 Anthony St

15 Filed 1927 C. HAMPTON JONES, M. D.

For _____ Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 20/27 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

Lobar Pneumonia - 3 days

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. H. Bolen M. D.

(Coroner)

2/21/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem Date of Burial 2-23 1927

20 UNDERTAKER Jas. M. Skinner ADDRESS 620 E. Lombard St

Very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19336

## CERTIFICATE OF DEATH

100-001

E 19336

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 214 S. Chapel St. 22-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma W. Maurer

(a) RESIDENCE NO. 214 S. Chapel St. 2 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 11 mos. 17 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mch. 8th 1925

| 7 AGE | Years | Months | Days 13 | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 1 | 11 | 17 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER William T. Maurer

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Anna Manley

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto. Md.

14 Informant William T. Maurer

(Address) 214 S. Chapel St.

Filed FEB 23 1927 19

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 21st 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 20, 1927, to Feb 21, 1927, that I last saw h 21 alive on Feb 21, 1927, and that death occurred, on the date stated above, at 7.45 a m.

The CAUSE OF DEATH* was as follows:

Acute Bronchio Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Grace L. Zeigler M. D.

2/21, 1927 (Address) 1007 E Balt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery — Date of Burial Feb 23d 1927

20 UNDERTAKER Lilly & Geiler — ADDRESS 400 S Wolfe St

very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E-19337 E-PLURAL DEATH

129 E 19337

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. 1016 E. 20th St., 9-46 Ward)

2-FULL NAME Katharine Louisa Albrecht

(a) RESIDENCE NO. 1016 E. 20th St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | white | widowed. |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Wm Albrecht.

6 DATE OF BIRTH (month, day, and year) April 24-1855

| 7 AGE | Years | Months | Days 26 | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 71 | 9 | 27 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work house-work

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER ~~Jos~~ Cristian Pletsch

11 BIRTHPLACE OF FATHER (city or town) ?

(State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) ?

(State or country) Germany.

14 Informant D. Estelle Marsteller

(Address) 1016 E. 20th St.

Filed FEB 23 1927 C. HAMPSON JONES, M. D.

Per R.K. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-20-1927.

17

I HEREBY CERTIFY, That I attended deceased from 11-28-, 1927, to 2-21-, 1927, that I last saw h[illegible] alive on 2-20-, 1927, and that death occurred, on the date stated above, at 12:40 p. m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) unknown yrs. mos. ds.

18 Where was disease contracted

If not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? physical signs

(Signed) Chester Piland, M. D.

2-20-1927 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial London Park Cem. Feb 23 1927

20. UNDERTAKER Los Joesdens Son ADDRESS 2078 Pac[illegible]

very important. See INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.–7-17-26–A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

E 19338

## CERTIFICATE OF DEATH

E 19338

1-PLACE OF DEATH

Forest Rd REGISTERED NO. 71

City of BALTIMORE: (No. Sieling Sanatorium Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilbur Wesley Stubb

(a) RESIDENCE NO. Sieling Sanatorium Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 1 mos. — ds. How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): Separated ~~Divorced~~

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 1867

7 AGE: Years 60 Months 1 Days —

IF LESS than 1 day ...hrs. or ...min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore md

PARENTS

10 NAME OF FATHER Charles E. Stubb

11 BIRTHPLACE OF FATHER (City or town)

(State or country) U S A, County md

12 MAIDEN NAME OF MOTHER Susan E. Miller

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore md

14 Informant George Joerdens

(Address) 217 E. Pleasant

15 Filed ..., 19 C. HAMPSON JONES, M. D. Registrar

FEB 23 1927 Per RK

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 21 1927

17 I HEREBY CERTIFY, That I attended deceased from 2/14, 1927, to 2/20, 1927.

That I last saw h[e] alive on 2/20, 1927

and that death occurred, on the date stated above, at 4 A.M. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Antecedent) ...

(duration) 0 yrs. 0 mos. 6 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 0 yrs. 0 mos. 7 ds.

18 Where was disease contracted if not at place of death? Don't know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) ... M. D.

(Address) 100 N. Howard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem Date of Burial: Feb 24 1927

20 UNDERTAKER: Jos Joerdens & Son ADDRESS 207 S. C...

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19339

## CERTIFICATE OF DEATH.

129 E 19339

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3440 Reisterstown Road St. 15-58 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Albert Griner

(a) RESIDENCE No. 3440 Reisterstown Road ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If ~~married~~, widowed, or ~~divorced~~ HUSBAND of (or) ~~WIFE of~~ Sophia Griner

6 DATE OF BIRTH (month, day, and year) Apr. 23-1843

7 AGE: Years 83 Months 9 Days 29 If LESS than 1 day, hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Gentleman

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

086

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF ~~FATHER~~ (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 21 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1st, 1926, to Feby 21, 1927.

that I last saw h~~e~~ alive on Feby 20, 1927.

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Chr Interstitial Nephritis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr Myocarditis

(duration) 15 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Shadyside Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Paul Brown, M. D.

Feb, 1927 (Address) 1837 Penn Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

14 Informant (Address) Mrs. Fred Kuhle (daughter) 3440 Reisterstown Road

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Shady Side Cemetery

DATE OF BURIAL: Feb 23 1927

15 Filed Feb 23 1927 C. HAMPSON JONES, M. D. Registrar KK

20 UNDERTAKER: Robt J Turner Son

ADDRESS 1942 N. Broadway

Spec.—1-10-21—M&T—1500 Bks.

19340 HEALTH DEPARTMENT—CITY OF BALTIMORE E 19340

# CERTIFICATE OF DEATH.

× 123

1-PLACE OF DEATH Maryland General Hospital REGISTERED NO. 11-24

CITY OF BALTIMORE: (No. ..... St., ..... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Kate Ginsberg

(a) RESIDENCE NO. Westminster Md. St., ..... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 14 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ginsberg

6 DATE OF BIRTH (month, day, and year): Aug 31, 1888

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 38 | 5 | 21 23 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: H W. (Housework)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Patapsco Md.

PARENTS

10 NAME OF FATHER: Wm. Jefferson Weiner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Clorinda Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs Kate Ginsberg

(Address): Westminster Md

15 Filed 8 23 1927 19 C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2 - 22 1927

17 I HEREBY CERTIFY, That I attended deceased from 2 - 8 , 1927 , to 2 - 22 , 1927 ,

that I last saw her alive on 2 - 22 , 1927 ,

and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Cholecystitis 9 yrs
" Cholelithiasis 2

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) acute Pancreatitis

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 2-9-27 Removal of Gallbladder

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. E. Zimmerman M. D.

, 19 (Address) Md. Gen'l Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bethel Cemetery Balto Co Md

DATE OF BURIAL: Feb 25 1927

20 UNDERTAKER: W M Ranton

ADDRESS: 222 S Mt

Spec.—7-17-26—A Co.—200 Bks.

E 19341

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

90 E 19341

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 501 N Linwood Ave St., 7-11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Damisz

(a) RESIDENCE NO. 501 N Linwood Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rose Damisz

6 DATE OF BIRTH (month, day, and year): May 1 1876

7 AGE — Years: 50 Months: 9 Days: 19 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 061

(b) General nature of industry, business, or establishment in which employed (or employer): Retired Police Officer

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Poland

PARENTS

10 NAME OF FATHER: Jacub Damisz

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Poland

12 MAIDEN NAME OF MOTHER: Unkown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Poland

14 Informant: Rose Damisz

(Address): 501 N Linwood Ave

Filed 2-23-1927 C. HAMPSON JONES, M. D. Registrar

Per RR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Feb 20 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 20, 19 27, to Feb 20, 19 27,

that I last saw h alive on 19,

and that death occurred, on the date stated above, at 430 a m.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 10 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) M. D.

2/22 19 27 (Address) 517 Eastern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary cem

Date of Burial: Feb 23 1927

20 UNDERTAKER: John M Welby

ADDRESS: 1803 Bank St

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

## CERTIFICATE OF DEATH.

E 19342

REGISTERED NO. B 10342

1-PLACE OF DEATH

City of BALTIMORE: (No. 209 Rock St. 18-7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hannah Nelson

(a) RESIDENCE NO. 209 Rock St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Peter Nelson

6 DATE OF BIRTH (month, day, and year): 9-26-1864

7 AGE: Years 63 | Months 4 | Days 23 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer): O'

(c) Name of employer

9 BIRTHPLACE (city or town): Balto.

(State or country): Md.

PARENTS

10 NAME OF FATHER: James Johnson

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Nova Scotia

12 MAIDEN NAME OF MOTHER: Angelina Wright

13 BIRTHPLACE OF MOTHER (city or town): Kent Co.

(State or country): Md.

14 Informant: Emma Simmons

(Address): 209 Rock St.

Filed FEB 23 1927 By K.H. Registrar

C. HAMPSON COLES M.D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: 2-19-27

17 I HEREBY CERTIFY, That I attended deceased from 1-14 1927, to 2-19-1927, that I last saw h[illegible] alive on 2-19, 1927, and that death occurred, on the date stated above, at 11.55 a m.

The CAUSE OF DEATH* was as follows:

Terminal Bronchio-pneumonia

(duration) yrs. 1 mos. 6 ds.

CONTRIBUTORY (Secondary): Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

2-21-1927 (Address) 209 Rock St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Lebanon Cemetery — Date of Burial: Feb 23 1927

20 UNDERTAKER: Peter A. Williams — ADDRESS 322 N. Schroeder St.

Very Important. See Instructions on Back of Certificates.

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19343

## CERTIFICATE OF DEATH.

8 E 19343

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital St. 19-29 WARD)

2-FULL NAME Evelyn Wall

(a) RESIDENCE NO. 525 S. Catherine St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 7 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 4, 1923

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 3 | 7 | 18 15 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Wall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Minnie Fuller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant (Address) Mrs. John Wall 525 Catherine St

15 Filed FEB 23 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 22 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 8th, 1927, to Feb 22, 1927, that I last saw her alive on Feb 22, 1927 and that death occurred, on the date stated above, at 2 10 P m

The CAUSE OF DEATH* was as follows:

Scarlet Fever

(duration) yrs. 1 mos 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Myron G. Tull, M. D.

2/23, 1927 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery DATE OF BURIAL Feb 25 1927

UNDERTAKER F. D. Wappler ADDRESS 150 N. Paca St

Spec.-7-17-26—A Co.—200 Bks.

E 19344

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

3 1 ✓

REGISTERED NO. E 19344

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hospital St. 25-7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J McDonald

(a) RESIDENCE NO. 2331 Washington Blvd. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M. | W. | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie McDonald

6 DATE OF BIRTH (month, day, and year) Jan 19 1852

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min.. |
|---|---|---|---|---|
| | 75 | 1 | 3 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) Ga.

(State or country)

PARENTS

10 NAME OF FATHER John McDonald

11 BIRTHPLACE OF FATHER (City or town) Ga

(State or country)

12 MAIDEN NAME OF MOTHER Sarah Hosler

13 BIRTHPLACE OF MOTHER (city or town) Ga.

(State or country)

14 Informant Mrs Jennie McDonald

(Address) 2331 Wash Blvd

15 Filed FEB 23 1927 16 FRANK J. JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 16-27 1927, to Feb 22 1927, that I last saw him alive on Feb 22 — 10.50 A.M. to 22, and that death occurred, on the date stated above, at 11 A.M. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of lungs, nephritis myocarditis, cardiac failure

(duration) 8 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) — yrs. — mos. 4 ds.

18 Where was disease contracted if not at place of death? in the army

Did an operation precede death? — Date of —

Was there an autopsy? Laboratory - Dr Reg - Clin.

What test confirmed diagnosis?

(Signed) H. John Graham M. D.

, 19 (Address) 1122 N Mount St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Loudon | Feb 25 1927 |
| 20 UNDERTAKER | ADDRESS |
| H. Cook | 502 E Lombard |

very important. See instructions on back of certificates.

Statement of OCCUPATION is

Spec.—12-9 25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19345

CERTIFICATE OF DEATH.

129 E 19345

1-PLACE OF DEATH

City of BALTIMORE: (No.) Balto City Hospital (Ward) 27

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stanislaus Parlinski

(a) RESIDENCE NO. Balto City Hospital St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? 38 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M. | W. | Widower |

3a If married, widowed, or divorced HUSBAND of (or) WIFE of — Parlinski.

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 56 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker - L

(b) General nature of industry, business, or establishment in which employed (or employer) O

(c) Name of employer

9 BIRTHPLACE (city or town) Poland

(State or country)

PARENTS

10 NAME OF FATHER Unknown -

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland.

14 Informant Mrs. Mary Hazuwski.

(Address) 1400 Aliceanna St

Filed FEB 23 1927 H. HERBERT JONES, M. D. Registrar

By KK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

2-18-27

17 I HEREBY CERTIFY, That I attended deceased from 6-27- 1923, to 2-18 1927

that I last saw him alive on 2-18 1927

and that death occurred, on the date stated above, at 10 30 A.M.

The CAUSE OF DEATH* was as follows:

1 Bilateral Pleuro-pneumonia & Chronic Interstitial [redacted]

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Terminal Bronchopneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

St. Stanislaus. Feb. 23 1927.

20 UNDERTAKER — ADDRESS

M. Sadowski. 705 S. Ann St.

Very Important. See Instructions on Back of Certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 19346 HEALTH DEPARTMENT—CITY OF BALTIMORE E 19346

101-601

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 238 South Ann St., 7-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward J.Cieslak,

(a) RESIDENCE NO. 238 South Ann ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 6 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male, | White, | Single, |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 5-1926.

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 0 | 6 | 17 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None,

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, MD.

PARENTS

10 NAME OF FATHER Joseph Cieslak,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Rose Gibowicz,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Joseph Cieslak, (Father)
(Address) 238 South Ann Street

15 Filed 19 [illegible] Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22, 1927

17 I HEREBY CERTIFY, That I attended deceased from [illegible], 19[illegible], to [illegible], 19[illegible], that I last saw h[illegible] alive on [illegible], 19[illegible], and that death occurred, on the date stated above, at 6. A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Orbicle Bronchitis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M.D.

19[illegible] (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St.Stanislaus Cemetary

DATE OF BURIAL: Feb. 24-19 27

20 UNDERTAKER: M J Sadowski

ADDRESS: 705 S.Ann

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

B 2 3 1927

C. HAMPSON JONES, M. D.

Registrar

Spec.—12-9-25—A Co.—200 Bks.

E 19347

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

74-002

REGISTERED NO. E 19347

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital 18-59 Ward)

2-FULL NAME Sigmund Rosenblatt

(a) RESIDENCE NO. 2107 Eutaw Pl Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henrietta H. Rosenblatt

6 DATE OF BIRTH (month, day, and year): July 13, 1850

7 AGE: Years 76; Months 7; Days 9; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country) Germany

PARENTS

10 NAME OF FATHER: Solomon Rosenblatt

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Germany

12 MAIDEN NAME OF MOTHER: Wilhelmina Oppenheimer

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Germany

14 Informant: Mr. Harold Rosenblatt

(Address) Bryan Ave

FEB 23 1927 P.M. C. HAMILTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-22 19 27

17 I HEREBY CERTIFY, That I attended deceased from 1-2 19 27 to 2-22 19 27, that I last saw h[illegible] alive on 2-22 19 27, and that death occurred, on the date stated above, at 4p. m.

The CAUSE OF DEATH* was as follows:

Arteria-sclerosis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Cerebral Embolism

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death!

Did an operation precede death! NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Clinical symptoms

(Signed) [illegible] M. D.

19 (Address) Sinai

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship

Date of Burial 2/25 1927

UNDERTAKER Lehrenbaum

538 Reisterstown

Very Important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19348

161-002

## CERTIFICATE OF DEATH.

REGISTERED E 19348

1-PLACE OF DEATH

City of BALTIMORE: (No. 109 S Carlton St. 1829 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant of Charles H. & Rena E. Meyers

(a) RESIDENCE NO. 109 S Carlton St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2/18/27

7 AGE

| Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|
| XXX | XXX | 4 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) Maryland

PARENTS

10 NAME OF FATHER Chas H Meyers

11 BIRTHPLACE OF FATHER (city or town) Balto.

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Rena E. Dahl

13 BIRTHPLACE OF MOTHER (city or town) Balto.

(State or country) Maryland

14 Informant Charles H. Meyers

(Address) 109 S. Carlton St.

2 3 1927 CHARLES J. JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/22/27

17 I HEREBY CERTIFY, That I attended deceased from 2/21 19 27, to 2/22/27, 19.....,

that I last saw h— alive on 2/21/27, 19.....,

and that death occurred, on the date stated above, at 2.30 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) .....yrs. .....mos. 4 ds.

CONTRIBUTORY (Secondary) Pneumonia & Dr Hutton (Coma)

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Bernard J. Ferry, M. D.

2/24, 1927 (Address) 910 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — Date of Burial: Feb. 23 1927

20 UNDERTAKER: E. B. Cook — ADDRESS 503 W. Baltimore St.

Very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19349

## CERTIFICATE OF DEATH.

129 E 19349

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1829 Edmondson Ave., ST. 19-27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johannah Lowe

(a) RESIDENCE NO. 1829 Edmondson Ave., ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced (or) WIFE of Thomas F. Lowe

6-DATE OF BIRTH (month, day, and year) Feb. 6th. 1853

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 74 | | 15 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Michael Kenealy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Thomas F. Lowe

(Address) 1829 Edmondson Ave.,

15 3 1927 C. HAMPSON JONES M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 21, 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 3, 1927, to Feb. 20, 1927, that I last saw her alive on Feb. 20, 1927, and that death occurred, on the date stated above, at 12:45 A m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis 5Yrs.

Chronic Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Can Van Ingen, M. D.

, 19 (Address) 24 N. Fulton Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mag Catedral — DATE OF BURIAL Feb. 24 1927

20 UNDERTAKER John G. Moore — ADDRESS Balto Md. 3006

TION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

91-92 E 19350

## CERTIFICATE OF DEATH

E 19350

REGISTERED NO. _____

1-PLACE OF DEATH

City of BALTIMORE: (No. 1416 Clarkson St. Ward 23-32)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Taylor

(a) RESIDENCE NO. 1416 Clarkson St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Walter P. Taylor

6 DATE OF BIRTH (month, day, and year): May 28, 1858

7 AGE: Years 68 Months 8 Days 29 IF LESS than 1 day ____hrs. or ____min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Samuel McCardell

11 BIRTHPLACE OF FATHER (City or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Ireland.

14 Informant: Walter Taylor (Address) 1416 Clarkson St.

23 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 21, 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1927, to Jan 21, 1927, that I last saw h[illegible] alive on Jan 21, 1927, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Duration Indefinite yrs. mos. ds.

CONTRIBUTORY (Secondary) Rheumatism

(duration) yrs. mos 2 ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) W. C. Campbell M. D.

Jan 22, 1927 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem. Date of Burial Jan 1927

20 UNDERTAKER: Margaret J. Flynn ADDRESS 1422 Light St

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 19351

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19351

## CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 104 (ST.) E. Fortam (WARD) 24-33

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John. P. Pickerton

(a) RESIDENCE NO. 104 E. Fort ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dorcas. E Pickerton

6 DATE OF BIRTH (month, day, and year) Nov 11, 1863

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 63 | 3 | 10 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Retired. 015

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Frederick Pickerton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Dorcas. E Pickerton

(Address) 104 E Fortam

15 Filed 3 1927 HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 21 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 14, 1927, to Feb. 21, 1927, that I last saw h alive on Feb. 21, 1927 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Uraemic Coma.

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Thos. F. Stevens, M. D.

2/27, 1927 (Address) 2818 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross M. A. Co

DATE OF BURIAL Feb 24 1927

20 UNDERTAKER William Cook

ADDRESS 502 E Wash.

THIS is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

Dr Bartlett

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19352 | CERTIFICATE OF DEATH | 129 E 19352

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1212 East Lafayette Ave St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Rhein

(a) RESIDENCE NO. 1212 East Lafayette Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Rhein

6 DATE OF BIRTH (month, day, and year) July 3 - 1857

| 7 AGE | Years | Months | Days | If LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 69 | 6 | 19 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry Kufer

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant John Rhein

(Address) 1212 E Lafayette

15 Filed C. HAMPSON JONES, M. D. Registrar

JUL 1927 Per

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1927

17 I HEREBY CERTIFY, That I attended deceased from 2/28/ 1926 to 2/22 1927

that I last saw her alive on 2/15 1927

and that death occurred, on the date stated above, at 1050 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

30 min.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Nephritis, Hypertension

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Course

(Signed) Geo. Adams Baetz M. D.

7/28 1927 (Address) 1516 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loraine Cemetery Date of Burial 7/25 1927

20 UNDERTAKER Wm Cook ADDRESS 502 E North Ave

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19353 31 E 19353

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St., 16-37 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John L. Johnson

(a) RESIDENCE NO. BALTIMORE CITY HOSPITALS St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | ? |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1864

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 63 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) [illegible]

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Sweden

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant

(Address) Records

15 Filed 2-23-1927 C. HAMPSON JONES, M. D. Registrar

Per RCH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 19 1927

17

I HEREBY CERTIFY, That I attended deceased from August 20 1925, to February 19, 1927,

that I last saw him alive on February 18, 1927,

and that death occurred, on the date stated above, at 1:15 A m.

The CAUSE OF DEATH* was as follows:

Fibroid Pulmonary Tuberculosis

Asthma

Chronic Myocarditis & Insufficiency

(duration) ?yrs. mos. ds.

CONTRIBUTORY Myocardial Failure

(Secondary)

(duration) yrs. mos. 5 ds.

18 Where was disease contracted

If not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? general & laboratory

(Signed) R. Hooper Lamb, M. D.

Feb. 23 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 19

20 UNDERTAKER ADDRESS

FEB 28 1927

Commissioner Health,

Very important. See instructions on back of certificates.

REV. NOV. 8 1926 ALL.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19354

E 19354

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St. 76 37 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ray Covert

(a) RESIDENCE NO. Paxton Ill. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | S. |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1904

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 23 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 240

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Ill

PARENTS

10 NAME OF FATHER Frank Covert

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ill

12 MAIDEN NAME OF MOTHER Mary—

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ill

14 Informant BALTIMORE CITY HOSPITALS

(Address) Records

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 22 1927

17

I HEREBY CERTIFY, That I attended deceased from May 28 1926, to February 22 1927, that I last saw him alive on February 27 1927, and that death occurred, on the date stated above, at 2:30 p m.

The CAUSE OF DEATH* was as follows:

Gonorrheal Arthritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? general & laboratory

(Signed) R. Hampson Smith M. D.

Feb 27 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

JOHNS HOPKINS HOSPITAL 19

20 UNDERTAKER ADDRESS

Commissioner of Health FEB 28 1927

Very Important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19355 E 19355

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. T.B. Ward) 1727 431

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Brown

(a) RESIDENCE NO. 1001 Pennsylvania ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1886 ?

7 AGE: Years 41 40? Months Days IF LESS than 1 day....hrs. or....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer G.W.D.

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town)

(State or country): Virginia

PARENTS

10 NAME OF FATHER Frank Brown

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Virginia

12 MAIDEN NAME OF MOTHER Julia Patrick

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Virginia

14 Informant (Address): Hospital Records

15 C. HAMPSON JONES, M. D. Registrar

3 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

February 18, 1927

17 I HEREBY CERTIFY, That I attended deceased from February 1, 19 27, to February 18, 19 27,

that I last saw h in alive on February 18, 19 27,

and that death occurred, on the date stated above, at 1.40 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary TB

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted Unknown

If not at place of death!

Did an operation precede death! No Date of

Was there an autopsy! No

What test confirmed diagnosis! Clinical

(Signed) W. McCallum, M. D.

2-19-27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL Date of Burial 19

20 UNDERTAKER ADDRESS

Commissioner Health

FEB 23 1927

Per Wm. E. WOODALL

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 19356

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19356

100-001

## CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1707 Orleans. ST. 6-4 WARD)

2-FULL NAME Simon P. Archer

(a) RESIDENCE No. 1707 Orleans. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | Col | Married. |

5a If married, widowed, or divorced HUSBAND of or) WIFE of Alice Archer.

6 DATE OF BIRTH (month, day, and year) Mar. 17 - 1874

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 53 | 11 | 23 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Junk dealer

(b) General nature of industry, business, or establishment in which employed (or employer) Junking

(c) Name of employer 0451

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Dont know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont know.

12 MAIDEN NAME OF MOTHER Dont know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Alice Archer

(Address) 1707 Orleans st

15 3 1927 C. HAMPSON JONES, M. D. Registrar

Per Ref

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2 - 22 - 1927

17

I HEREBY CERTIFY, That I attended deceased from 2 - 19 - 1927, to 2 - 22 - 1927,

that I last saw h alive on 2 - 21 - 1927,

and that death occurred, on the date stated above, at 4,20 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

2-23-1927 (Address) 611 N. Carey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Norfolk Va

DATE OF BURIAL Feb 24 1927

20 UNDERTAKER John W Henderson

ADDRESS 1502 E. Monument

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19357

## CERTIFICATE OF DEATH.

129 E 19357

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 701 W. Lexington St. Ward 4-16)

2-FULL NAME Abraham I. Harris

(a) RESIDENCE NO. 701 W Lexington St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Esther Harris

6 DATE OF BIRTH (month, day, and year): July 22 1897

7 AGE — Years: 29 — Months: 7 — Days: 1 — If LESS than 1 day.... hrs. or.....min.: 23

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Insurance Agent

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md

PARENTS

10 NAME OF FATHER Solomon Harris

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country) Md

12 MAIDEN NAME OF MOTHER Sadie Isenberg

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md

14 Informant: Solomon Harris

(Address) 701 W Lexington St.

15 1927 C. HAMPSON JONES, M. D. Registrar

By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/23/1927

17 I HEREBY CERTIFY, That I attended deceased from 2/20/1927 to 2/23/1927

that I last saw h.. alive on 2/23/1927

and that death occurred, on the date stated above, at 1045 A. M.

The CAUSE OF DEATH* was as follows:

Pulmonary edema

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Chronic nephritis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. H. Weinberger M. D.

2/23/1927 (Address) 724 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Chev Shalom Cemetery — Date of Burial: Feb 26 1927

20 UNDERTAKER: J. Ahrens & Co — ADDRESS: 231 Eastern Ave

Very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19358

129 E 19358

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 12-50 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Ewan

(a) RESIDENCE NO. 2538 Greenmount St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | married |

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary W. Ewan

6 DATE OF BIRTH (month, day, and year) Oct 7/1877

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 49 | 4 | 14 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stone Mason

(b) General nature of industry, business, or establishment in which employed (or employer) 075

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) Scotland

PARENTS

10 NAME OF FATHER John Ewan

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Scotland

12 MAIDEN NAME OF MOTHER Margaret Mitchell

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Scotland

14 Informant Mary W. Ewan

(Address) 2538 Greenmount Ave

Filed 3-1927 C. HAMPSON JONES, M. D. Registrar

Per _____

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 21/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Meningitis-(Chronic Mastoditis, Myocarditis & Nephritis)

(Autopsy at Sinai Hospital)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. M. Pullen M. D. (Coroner)

19 2/23/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?_____

Former or usual residence_____

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Date of Burial Feb 24 1927

20 UNDERTAKER J. M. Cook ADDRESS 501 E North Ave

Very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 19359 74-021 E 19359

REGISTERED NO. 2572

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hosp. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John R Egan

(a) RESIDENCE NO. 1027 Lexington St. Mantle Pk. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | Married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 1 1872

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|---|
| | 54 | 9 | 21 20 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Street Gang

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Patrick Regan

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Edna Jones

(Address) 3019 Bloyne Ave

15 Filed FEB 24 1927 C. HAMPSON JONES, M. D. Registrar

Per R C

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 Feb 22, 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 22 19 27 to Feb 22 19 27

that I last saw h in alive on Feb 22 19 27

and that death occurred, on the date stated above, at 2:15 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos. 1 da.

CONTRIBUTORY (Secondary) Hypertension

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death? 1027 Lexington St

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J M Buckley M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| New Cathedral | Feb 25 1927 |
| **20 UNDERTAKER** | **ADDRESS** |
| Wm. Miller & Sons | 2012 Wilkins Ave |

very important. See instructions on back of certificates.

Cor.—12-9-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

## CERTIFICATE OF DEATH.

E 19360
1-PLACE OF DEATH

E 19360
REGISTERED NO.

City of BALTIMORE: (No. Mercy Hospital St. 23-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Oliver D. Smith

(a) RESIDENCE NO. 102 E. Cross St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie D. Smith

6 DATE OF BIRTH (month, day, and year) Aug. 12, 1883

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 43 | 6 | 10 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) J

(c) Name of employer

9 BIRTHPLACE (city or town) Rockingham

(State or country) N. C.

PARENTS

10 NAME OF FATHER John Smith

11 BIRTHPLACE OF FATHER (city or town)

(State or country) N. C.

12 MAIDEN NAME OF MOTHER Annie M.Deas

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Rockingham, N. C.

14 Informant Mrs. Sarah J. Schutte

(Address) 611 N. Lakewood Ave.

15 Filed C. HAMILL JONES, M. D.

B 24 1927 RK Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 22 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Friday (duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) W. H. Riley, M. D.
(Coroner)

Feb. 24, 1927 (Address) 1432 E. Cross

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos., 2 days ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| St Mary's Hampden | Feb. 25 1927 |
| **20 UNDERTAKER** | **ADDRESS** |
| John F. Denny | 715 Light St |

Very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19361

## CERTIFICATE OF DEATH.

E 19361

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3508 E Fairmount Ave ST. 46-39 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dona Elizabeth Schuyler

(a) RESIDENCE NO. 3008 E Fairmount Ave ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 5 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 21- 1924

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs. or ..min. |
|---|---|---|---|---|
| | 2 | 5 | 1 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Edw H Schuyler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Talbott Co Md

12 MAIDEN NAME OF MOTHER Eleanora Christian

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Edw H Schuyler
(Address) 3008 E Fairmount Ave

Filed B 24 1927 C. HAMPSON JONES, M. D. Registrar
By R K

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-22-1927

17 I HEREBY CERTIFY, That I attended deceased from 1-1-1927 to 2-22-1927 that I last saw h[illegible] alive on 2-22-1927 and that death occurred, on the date stated above, at 7.10 p.m.

The CAUSE OF DEATH* was as follows:

Pertussis

(duration) yrs. 1/2 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. Reginald Sanders M. D.

(Address) 800 Hamilton Ave

*State the Disease Causing Death or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cem — DATE OF BURIAL Feby 27 1927

20 UNDERTAKER John Merich — ADDRESS 2005 Eutaw St

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19362

E 19362

## CERTIFICATE OF DEATH.

74-001

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 2832 Harford Ave St., 9-46 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry G. Niemann

(a) RESIDENCE NO. 2832 Harford Ave St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma J Niemann

6 DATE OF BIRTH (month, day, and year) June 10/1868

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 58 | 8 | 12 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) Balto. City

(c) Name of employer Fire Dept.

9 BIRTHPLACE (city or town)_____

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Joseph Niemann

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Germany

12 MAIDEN NAME OF MOTHER Thersa Pohlgies

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Germany

14 Informant Emma J Niemann

(Address) 2832 Harford Ave

15 Filed FEB 24 1927 Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22-27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Cerebral Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Patterson M. D.

(Coroner)

2/23/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery Date of Burial February 24, 27

20 UNDERTAKER Henry Storch Son ADDRESS 1301 E Eager St.

Very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 19363

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19363

100-02

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 231 S Durham St. 7-4 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fannie Morris

(a) RESIDENCE NO. 232 S Durham St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: colord

5 Single, Married, Widowed, or Divorced. (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 7, 1925 Oct 1 1926

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 1 | 4 5- | 14 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Mt. P

(State or country)

PARENTS

10 NAME OF FATHER Leigh Morris

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Hattiesburg Va

12 MAIDEN NAME OF MOTHER Hattie Crockett

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Sarah Crockett

(Address) 112 S. Bond st.

FEB 24 1927 Filed

Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 21 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest

(Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Cap. Bronchitis

(duration) 6 days

CONTRIBUTORY (Secondary) Exhaustion

(duration) 2 days

Feb 24 1927 (Signed) G C Peden M. D.

(Coroner)

19 (Address) 43 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cemetery — Date of Burial: Feb 24 1927

20 UNDERTAKER: Edward Bryan — ADDRESS: 1681 Orleans St

Spec.—12-9-25—A Co.—200.Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19364

## CERTIFICATE OF DEATH.

90 E 19364

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 414 E. Preston Street St. 11-14 Ward)

2-FULL NAME Margaret M. Nies

(a) RESIDENCE NO. 414 E. Preston Street St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John L. Nies

6 DATE OF BIRTH (month, day, and year) 10/6/1864

| 7 AGE Years | Months | Days | IF LESS than 1 day ...hrs. or ...min. |
|---|---|---|---|
| 62 | 4 | 16 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Casper Haucht

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Haucht

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Rita Nies

(Address) 414 E. Preston Street

15 Filed ..., 19... [illegible] JONES, M. D. Registrar

2 4 1927 By [illegible]

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 21 1927 to Feb 22, 1927, that I last saw h[illegible] alive on Feb. 22, 1927, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Decompensated

(duration) ...yrs. ...mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted ✓

if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? None

(Signed) Thos F.H. Simons, M. D.

2/26 1927 (Address) 2878 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — Date of Burial 2/25 1927

20 UNDERTAKER George J. Ruth — ADDRESS 1735 Harford Ave

Very Important. See Instructions on Back of Certificate.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19365

## CERTIFICATE OF DEATH.

X 101-001

E 19365

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St. 26-32 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stanley Stanczykowicz

(a) RESIDENCE NO. Furnace Station Rd. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Single |

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1894

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 33 32 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Laborer

(b) General nature of industry, business, or establishment to which employed (or employer) Saloon

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Hospital Records

(Address)

B24 1927 C. HAMPSON JONES, M. D.

Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 28 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows: Lobar Pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

Feb. 28 1927 (Signed) G. C. Blades M. D.

(Coroner)

(Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart of Mary Date of Burial Feb 29 1927

20 UNDERTAKER John M Weber ADDRESS 1903 Bank St

Very important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19366

## CERTIFICATE OF DEATH

E 19366

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Emergency Hospital St. 20-69 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sheldon Chapman

(a) RESIDENCE NO. 2416 Frederick Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1883

1883

7 AGE: Years 44 Months Days

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Policeman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Police Dept. Baltimore City

9 BIRTHPLACE (city or town): Baltimore City

(State or country)

PARENTS

10 NAME OF FATHER: Jas Chapman

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant: Robert Brooks

(Address): Calhoun & Hollins Sts

15 Filed FEB 24 1927 Per R.P. C. HAMILTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Feb. 23, 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 7, 19 27, to Feb. 23, 19 27, that I last saw h. in alive on Feb. 23, 19 27, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Carbuncle of Back Septicaemia

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of Jan 14 1927

Was there an autopsy? Yes

What test confirmed diagnosis? Blood Examination

(Signed) J Mackey M. D.

. 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: LOUDON PARK CEM

Date of Burial: 2/26 1927

20 UNDERTAKER: Robert Brooks & Son

ADDRESS: Calhoun & Hollins Sts

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Pks.

E 19367

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 19367

1-PLACE OF DEATH

City of BALTIMORE: (No. 1027 W. Fayette St. (If not in hospital) Ward 18-26)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amanda C. Hall.

(a) RESIDENCE NO. 1027 W. Fayette St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed or divorced (or) WIFE of: Charles C. Hall

6 DATE OF BIRTH (month, day, and year): Sept 1846

7 AGE — Years: 80 — Months: 5 — Days: — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore

(State or country): Maryland

PARENTS

10 NAME OF FATHER: James Gardner

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Maryland

12 MAIDEN NAME OF MOTHER: Emily Spry

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Maryland

14 Informant: Fannie E. Parris

(Address) 1027 W. Fayette St.

Filed FEB 24 1927 HARRY JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 23 1927

Feb 23-27

17 I HEREBY CERTIFY, That I attended deceased from Apr 4 1926 to Feb 23 1927,

that I last saw her alive on Feb 23 1927,

and that death occurred, on the date stated above, at 5.30 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): Senile Arteriosclerosis & Myocarditis

(duration) over 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Syr

(Signed) Fannie E. Parris M. D.

Feb 23. 1927 (Address) 1203 W. Fayette St,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Bear, Feby 25 1927

20 UNDERTAKER: John A. Mitchell ADDRESS 1900 Eutaw Place

Very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19368

## CERTIFICATE OF DEATH.

159 002 E 19368

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1064 W. Beverly ST. 23-31 (WARD)

2-FULL NAME Rene Sunderland

(a) RESIDENCE NO. 106 W. Beverly ST., ..... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Feb 23, 1927

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | | | 3 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... ditto

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Wm. H. Sunderland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Columbia

12 MAIDEN NAME OF MOTHER Flora Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Wm. H. Sunderland (Address) 106 W. Beverly St.

15 Filed FEB 24 1927 19 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 23 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 23, 1927 to Feb 23, 1927.

that I last saw h[illegible] alive on Feb 23 1927.

and that death occurred, on the date stated above, at 11:55 P.M.

The CAUSE OF DEATH was as follows: Tetanus Infantum

Arale

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. H. Hawkins, M. D.

2/24, 1927 (Address) 6 E. Randolph

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem. DATE OF BURIAL: Feb 24 1927

20 UNDERTAKER: A. Howard Evans ADDRESS: 386 E. Fort Ave

FROM A VERY important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19369

## CERTIFICATE OF DEATH.

103

E 19369

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 331 Dolphin (St.) 11-24 (Ward)

2-FULL NAME Anna Haugh Reeder

(a) RESIDENCE NO. 331 Dolphin St. (St.), (Ward)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred entire life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | widow |

5a If ~~married~~, widowed, or ~~divorced~~
~~HUSBAND of~~
(or) WIFE of Late Andrew J. Reeder

6 DATE OF BIRTH (month, day, and year) 28th April, 1842

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| 84 | " | 10 | 25 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore County.

PARENTS

10 NAME OF FATHER John Haugh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Edinburgh, Scotland.

12 MAIDEN NAME OF MOTHER Rachel Hamilton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore County

14 Informant Son Clarence Reeder
(Address) 331 Dolphin St

15 Filed FEB 24 1927 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 18 1927 to Feb. 22 1927 that I last saw h[illegible] alive on Feb. 22 1927 and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) old age

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical.

(Signed) Herbert C Blake, M. D.

2-25 1927 (Address) 1014 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem

DATE OF BURIAL Feb 25 1927

UNDERTAKER H. Jenkins Sons Co

ADDRESS Edmondson Ave & Collington Ave

Spec. -7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19370 + 124 V

## CERTIFICATE OF DEATH

E 19370

1-PLACE OF DEATH University Hospital REGISTERED NO.

City of BALTIMORE: (No. Lund and Green St. 430 and Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard W. Hinton

(a) RESIDENCE NO. 210 Bloomsbury ave. St. Ward Catonsville, Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lovonia Hinton

6 DATE OF BIRTH (month, day, and year) Jan 10 1869

7 AGE: Years 58 yrs Months 1 Days 14 IF LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bookkeeper

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Enoch R H Hinton

11 BIRTHPLACE OF FATHER (City or town)
(State or country) Howard Co Md

12 MAIDEN NAME OF MOTHER Martha Hinton

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Md

14 Informant H. Lawson Hinton
(Address) 210 Bloomsbury Ave Catonsville Md

Filed 3 24 1927 C. HAMPSON JONES, M. D.
Registrar
Per R H

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 24th 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 14, 1927, to 2-24-, 1927, that I last saw h/ alive on 2-24 1927, and that death occurred, on the data stated above, at 1:24 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Cystitis with Empyema of Gall Bladder

duration ____ yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia with Pulmonary Edema

duration ____ yrs. ____ mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of 2-21-27

Was there an autopsy? Diagnosis Confirmed Gall Bladder

What test confirmed diagnosis? Operation & Surgical

(Signed) W. C. Lawson, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet — Date of Burial Feb 26 1927

20 UNDERTAKER George J Smith — ADDRESS 1532 Hollins St

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19371

## CERTIFICATE OF DEATH.

31

E 19371

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 425 N Freemont St. 17-26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo Wilson

(a) RESIDENCE NO. 425 N Freemont Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | C | Married |

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Levinia Wilson

6 DATE OF BIRTH (month, day, and year) May 1 1881

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 45 | 9 | 20 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto md.
(State or country)

PARENTS

10 NAME OF FATHER John H Wilson

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Charlotte Boyer

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Levinia Wilson
(Address) 425 N. Freemont Ave

15 Filed FEB 24 1927 Registrar C. HAMPSON JONES, M.D.

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 21 1927

17

I HEREBY CERTIFY, That I attended deceased from Nov. 1926 to Feb 21 1927.

that I last saw him alive on Feb 20 1927.

and that death occurred, on the date stated above, at 9.50 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R. Young, M. D.

(Address) 642 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Mt. Auburn Cemetery | 2/25/1927 |
| UNDERTAKER | ADDRESS |
| Mrs. Geo. H. Holland | 1651 Division St |

IMPORTANT. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19372

## CERTIFICATE OF DEATH

E 19372

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1738 Alice Ave St. 7-A Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence H. Meeker

(a) RESIDENCE NO. 1738 Alice Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of M. Louisa Meeker

6 DATE OF BIRTH (month, day, and year) March 1872

| 7 AGE | Years | Months | Days | IF LESS than 1 day ... hrs. or ... min. |
|---|---|---|---|---|
| | 54 55 | 11 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md.

PARENTS

10 NAME OF FATHER Clarence Meeker

11 BIRTHPLACE OF FATHER (City or town) Balto

(State or country) Md.

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Not Known

14 Informant Mrs. Louisa Meeker

(Address) 1738 Alice Ave H

15 Filed 2-24 1927 C. HARRISON JONES, M. D. Registrar

By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 22 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 4 1926 to Feb 22 1927

that I last saw h alive on Feb 22 1927

and that death occurred, on the data stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows: Cancer of Stomach (Carcinoma)

(duration) 3 yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) [illegible] M. D.

2/25 1927 (Address) 1600 N. Linwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Mount Carmel Cemetery | Feb. 24 1927 |
| 20 UNDERTAKER | ADDRESS |
| Henry Sander & Sons, Inc | 1710 Fleet St. |

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

# E 19373

## HEALTH DEPARTMENT—CITY OF BALTIMORE

49 E 19373

### CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 27 Ward 53) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas S. Wagner

(a) RESIDENCE NO. Roland Park Apts St. Balto Co Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hattie Sanner

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 60 | -- | -- | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER John Wagner

11 BIRTHPLACE OF FATHER (city or town)

(State or country) New York

12 MAIDEN NAME OF MOTHER Elizabeth Fales

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant Mrs. Hattie S. Wagner

(Address) Upland Road, Roland Park

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

P.M.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Feb 23, 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 22, 19 27, to Feb 23, 19 27, that I last saw h.xxx alive on Feb 23, 19 27, and that death occurred, on the date stated above, at. 8.10 P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

c/c Carc. of bladder ? (Malignant epithelioma?) (new)

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart failure 2 hrs

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Autopsy + Clinical history

(Signed) C. Hyman, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Loudon Park Cemetery — 2/26 19 27

20 UNDERTAKER — ADDRESS

Henry W. Myers & Son 805 N. Calvert

Very Important. See instructions on back of certificates.

RECORD OF OCCUPATION 18

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19374

## CERTIFICATE OF DEATH.

E 19374

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2711 Benard ST. 12-51 WARD 90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susanah Sleckela

(a) RESIDENCE No. 2711 Benard ST., ... WARD ...
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Charles J. Sleckela

6 DATE OF BIRTH (month, day, and year) Mar 10-1844

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 82 | 11 | 13 / 12 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard Co.

PARENTS

10 NAME OF FATHER Bernard McCrossin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Leland

12 MAIDEN NAME OF MOTHER Cordelia Knox

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mr Charles J Sleckela
(Address) 2711 Benard St

15 Filed 4 1927 C. HAMPSON JONES, M. D. Registrar
Per ack

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 23 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept 15, 1923, to Feb 23, 1927, that I last saw h~~e~~ alive on Feb 22, 1927, and that death occurred, on the date stated above, at 1030 A. m.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart - Dilatation.

(duration) 4 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema Fatal Attack

(duration) ... yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) R. B. Normal M. D.

2-27-1927 (Address) 3643 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral DATE OF BURIAL Feb 25 1927

20 UNDERTAKER A S Marshall ADDRESS 3539 Fall Rd

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

19375

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 19375

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 808 W Franklin ST. 18-16 WARD)

2-FULL NAME Charles Hall

(a) RESIDENCE NO. 808 W Franklin ST., ..... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or ~~WIFE of~~: Mary Hall

6 DATE OF BIRTH (month, day, and year): Aug - 1878

7 AGE — Years: 48 — Months: 6 — Days: — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Hod Carrier

(b) General nature of Industry, business, or establishment in which employed (or employer): Building

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Rocky Mountain N. C

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mary Hall.

(Address) 808 W Franklin

15 4 1927 C. HAMPSON JONES, M. D. Registrar

By ...

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feby 21. 1927

17 I HEREBY CERTIFY, That I attended deceased from Feby 18. 1927. to Feby 21. 1927.

that I last saw h~~m~~alive on Feby 21. 1927.

and that death occurred, on the date stated above, at 5-10 P. m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) W. S. Howell M. D.

19 27 (Address) 119 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem

DATE OF BURIAL: 2/25 1927

20 UNDERTAKER: Byron Wright

ADDRESS 1218 McElderry

Instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

37 E 19376

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19376

## CERTIFICATE OF DEATH.

139

1-PLACE OF DEATH

JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ) ST., 9-46 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude Kleinsmith

(a) RESIDENCE No. 2921 Gaylord St ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry A. Kleinsmith

6 DATE OF BIRTH (month, day, and year) January [illegible] 1885

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 42 | 1 | 12 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Practical Nurse

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md -

PARENTS

10 NAME OF FATHER Michael McCusker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md -

12 MAIDEN NAME OF MOTHER Mary Morris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md -

14 Informant Friends -

(Address) JOHNS HOPKINS HOSP

15 1927 C. HAMPSON JONES, M. D. Registrar

Per [illegible]

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb 18, 1927, to Feb 22, 1927, that I last saw her alive on Feb 22, 1927 and that death occurred, on the date stated above, at 2 01/4 m.

The CAUSE OF DEATH* was as follows:

Peritonitis

myocardial failure. (Cancer)

(duration) yrs mos 1 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 2/21/27

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) H. C. Smith, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL 2/25/27

20 UNDERTAKER Chas. J. Wand & Son — ADDRESS 118 W. Mt. Royal Ave

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19377

## CERTIFICATE OF DEATH.

129 E 19377

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hosp. St. 27-30 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm C Walker

(a) RESIDENCE NO. 117 W Barre St St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | ? |

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) R 56

| 7 AGE Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|
| 71 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ship Caulker

(b) General nature of industry, business, or establishment in which employed (or employer) 615

(c) Name of employer

9 BIRTHPLACE (city or town) Va

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ✓

14 Informant

(Address)

15 FILED 2-4 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

2-21-27

17 I HEREBY CERTIFY, That I attended deceased from 2-7 19 27 to 2-21 19 27

that I last saw him alive on 2-21 19 27

and that death occurred, on the date stated above, at 2 1/2 P.M.

The CAUSE OF DEATH* was as follows:

Benign Prostatic Hypertrophy

Chronic Interstitial Nephritis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) H Blueyed M. D.

19 (Address) Balto City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 19

JOHNS HOPKINS HOSPITAL FEB 24 1927

20 UNDERTAKER ADDRESS

Commissioner Health.

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 19378

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19378

## CERTIFICATE OF DEATH.

25-75-101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Marshall Court St. (Ward) Rear 10-1/2 N. Brooklyn.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret P. Thomas

(a) RESIDENCE No. Marshall Ct Brooklyn ST., ..... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. 9 mos. 13 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | Wh | Widowed. (deceased) |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of John Franklin Thomas

6 DATE OF BIRTH (month, day, and year) May 10-1851

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 75 | 9 Mos | 13 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home 66

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) ..... (State or country) Maryland

PARENTS

10 NAME OF FATHER Elijah Vermillion

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unobtainable

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Maryland.

14 Informant Son: Richd E. Thomas
(Address) Brooklyn

15 4 1927 C. HAMPSON JONES, M. D.
Registrar
Per .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 23rd 1927

17

I HEREBY CERTIFY, That I attended/deceased from Feb 17th 27, to Feb 23rd 27, that I last saw h[illegible] alive on Feb 23rd 27, and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia, Lobar.

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Robert W Johnson, M. D.

, 19 (Address) Brooklyn,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Cedar Hill Cemetery | Feb 26 1927 |
| 20 UNDERTAKER | ADDRESS |
| George A. Schwatt | 2101 Chalk Ave. |

FROM IS very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 19379

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19379

## CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1927 Hollins St. ST. 20-28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Ann Murphy

(a) RESIDENCE NO. 1927 Hollins St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John J. Murphy

6 DATE OF BIRTH (month, day, and year) Sept. 22, 1857

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min |
|---|---|---|---|---|
| | 69 | 5 | 1 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Patrick Hunt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Ann (Unknown)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Miss Gertrude Murphy

(Address) 1927 Hollins St.

15 Filed 4 1927 C. HAMPSON JONES, M. D. Registrar

By [illegible]

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 23, 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 23, 1927, to Feb. 23, 1927

that I last saw her alive on Feb. 23, 1927

and that death occurred, on the date stated above, at 10:20 Am.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis 2 Yrs.

Chronic Myorcorditis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Dilitation of Heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

~~What test confirmed diagnosis~~ Edw. Kendall

(Signed) , M. D.

2/24, 1927 (Address) 24 N. Fulton Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL Feb. 26 1927

20 UNDERTAKER Joseph B. Cook

ADDRESS 1003 N. Eutaw St.

Spec.—1-10-21—M&T—1500 Bks.

E 19380

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19380

## CERTIFICATE OF DEATH.

51

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 632. Baker. ST. 15-21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriet Coe.

(a) RESIDENCE NO. 632 Baker. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Coe.

6 DATE OF BIRTH (month, day, and year): Oct 6, 1875

7 AGE — Years: 51 — Months: 4 — Days: 16. — If LESS than 1 day, ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at home. 137

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Howard co md.

PARENTS

10 NAME OF FATHER: John Coe

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Co. md.

12 MAIDEN NAME OF MOTHER: Harriet Bonds.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Howard Co. Md.

14 Informant: Annie Coe.

(Address): 632. Baker St

15 C. HAMPSON JONES, M. D. Registrar

4 1927

Per Pct 11

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 22 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 17, 1927, to Feb 22, 1927, that I last saw h-e alive on Feb 22, 1927 and that death occurred, on the date stated above, at 8 55 A. m.

The CAUSE OF DEATH* was as follows:

Acute Inflamatory Rheumatism

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Acute Endocarditis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Marcellus E. Toney, M. D.

, 19 (Address) 1745 N Carey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Cemetery

DATE OF BURIAL: 2/25 1927

20 UNDERTAKER: Mrs Geo. H. Dennis per T. E. Nelson

ADDRESS: 1303 Pressman

IMPORTANT. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19381

E 19381

## CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

City of BALTIMORE: (No. 528 Patapsco ave. St., Brooklyn 25-75 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Avarila Sunderland

(a) RESIDENCE NO. 528 Patapsco Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. 7 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Leonard Sunderland

6 DATE OF BIRTH (month, day, and year): 7/10/05

7 AGE — Years: 21 | Months: 7 | Days: 12 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Ed. S. Wakeland

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Mary E. Lantz

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Md.

14 Informant: Ed. S. Wakeland

(Address): 528 Patapsco.

Filed: 2 4 1927

C. HARRISON JONES, M. D.

Registrar

P—

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 22 19 27

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 19 27 to Feb 22 19 27

that I last saw h alive on Feb 22 19 27

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) Indefinite yrs. mos. ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? Date of

Was there an autopsy? H. Emmett Campbell

What test confirmed diagnosis?

(Signed) M. D.

(Address) 1640 Harlem

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem

Date of Burial: 2/25/1927

20 UNDERTAKER: J. J. Jakey & Sons

ADDRESS: 318 Light St.

Very Important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19382 90 E 19382

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO. 26-37

City of BALTIMORE: (No. [redacted] St. [redacted] Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dominic K. Maier

(a) RESIDENCE NO. BALTIMORE CITY HOSPITALS St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1841

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 86 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Farm

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Switzerland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant

(Address) Records

15 Filed [redacted] C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 20 1927

17 I HEREBY CERTIFY, That I attended deceased from August 20, 1925, to February 20, 1927, that I last saw him alive on February 19, 1927, and that death occurred, on the date stated above, at 7-30 A m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) 6 yrs. 3 mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? General Laboratory

(Signed) R. Hilopa Lundt, M. D.

Feb 23 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Hill Cemetery Date of Burial: Feb 25 1927

20 UNDERTAKER: John J. Foley & Son ADDRESS: 311 Light

Very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—300 Bks.

E 19383

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19383

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

REGISTERED NO. 90

City of BALTIMORE: (No. [redacted] St., 11-15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lee Rider

(a) RESIDENCE NO. 703 Saint Paul St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1856

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 71 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer) City

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) New York

PARENTS

10 NAME OF FATHER George Rider

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant

(Address) Records

BALTIMORE CITY HOSPITALS

C. HAMPSON JONES, M. D.

15 [illegible], 19

4 1927 P.C. ARH Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 23 1927

17

I HEREBY CERTIFY, That I attended deceased from November 15 1926, to February 23, 1927, that I last saw him alive on February 23, 1927, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Senility

Chronic Myocarditis & Interstitial Nephritis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? general & laboratory

(Signed) R. Hooper Smith, M. D.

Feb 28 1927 (Address)

BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Laurel Cemetery | 2/28/1927 |
| **20 UNDERTAKER** | **ADDRESS** |
| C. Peter Sons | 1318 Light St |

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 19384

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 19384
REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2871 Woodbrook Ave ST. 13-54 WARD)

2-FULL NAME Fruma Rose Deane

(a) RESIDENCE No. 2871 Woodbrook Ave ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? 33 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Solomon Deane

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 71 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Isaac Rabinowitch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Solomon Deane
(Address) 2871 Woodbrook Ave

15 Filed 2 5 1927, 19 [illegible] Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/24 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 24, 1926, to Feb. 24, 1927, that I last saw her alive on Feb. 24, 1927 and that death occurred, on the date stated above, at 7 00 m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis followed by partial recovery - Lobar Cerebral hemorrhage

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Smith, M. D.

2/24, 1927 (Address) 927 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Hebrew Friendship | 2/27 1927 |

20 UNDERTAKER Jack Lewis ADDRESS 1429 E Baltimore

FILL IN very important — See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19385

## CERTIFICATE OF DEATH.

90 E 19385

REGISTERED NO.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St. 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Bamster

(a) RESIDENCE NO. 729 Henrietta St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Negro | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1856

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 71 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER Frank Bamster

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Regiah —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant

(Address)

Filed FEB 25 1927

BALTIMORE CITY HOSPITALS

FRANK J. WEBB, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 24 1927

17

I HEREBY CERTIFY, That I attended deceased from November 3, 1926, to February 21, 1927, that I last saw him alive on February 21, 1927, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Cirrhosis

Chronic Myocarditis & Insufficiency

Emphysema

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. mos. 5 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? general & laboratory

(Signed) R. Hooper Lintl M. D.

Feb 25 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Mt. Auburn | 2-20-19 27 |
| 20 UNDERTAKER | ADDRESS |
| John H. Toadvine | 1027 Hand Hill |

very important. See instructions on back of certificates.

Spec. –7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19386

## CERTIFICATE OF DEATH

129 E 19386

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 153 W Henrietta St. 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Simmons

(a) RESIDENCE NO. 153 W Henrietta St. 23 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1890

7 AGE: Years 37 Months - Days -

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Steredore

(c) Name of employer: B. & O R R

9 BIRTHPLACE (city or town) (State or country): Jamaica B.W.I.

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (City or town) (State or country): Jamaica B.W.I.

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Jamaica B.W.I.

14 Informant: Anna Henson

(Address) 153 W Henrietta St.

15 Filed FEB 25 1927 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/22/27

17 I HEREBY CERTIFY, That I attended deceased from 2/20/27, 19..., to 2/22/27, 19..., that I last saw him alive on 2/22/27, 19..., and that death occurred, on the date stated above, at 6-30 P.M.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

about (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis about (duration) yrs. 6 mos. ds.

18 Where was disease contracted

If not at place of death? None

Did an operation precede death? No Date of

Was there an autopsy? No. Clinical

What test confirmed diagnosis?

(Signed) P. Conley, M. D.

2/23/27 (Address) 1708 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: National — Date of Burial 2-26 1927

20 UNDERTAKER: John H. Toadvine — ADDRESS 1127 Druid Hill

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19387

## CERTIFICATE OF DEATH.

128 E 19387

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1209 Upton St., 1-23 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Dix

(a) RESIDENCE No. 1209 Upton St., Ward Virginia

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Victoria Dix

6 DATE OF BIRTH (month, day, and year) July 1885

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs. or ..min. |
|---|---|---|---|---|
| | 42 | - | - | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cooper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Accomac Co Va

PARENTS

10 NAME OF FATHER Thomas Cuttler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Dix

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Victoria Dix (Address) Crisfield Md

15 Filed FEB 25 1927 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 23 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 5, 1927, to Feb 23, 1927, that I last saw h alive on Feb 23, 1927 and that death occurred, on the date stated above, at 4.08 P m.

The CAUSE OF DEATH* was as follows:

Nephritis (Chronic)

(duration) yrs. 4 mos 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) R. Calder, M. D.

, 19 (Address) 1209 Upton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOV Whiteville Accomac Co Va — DATE OF BURIAL 2-26 1927

20 UNDERTAKER John H. Tordrow — ADDRESS Maud Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. STATE NUMBER OF CERTIFICATE.

TION is very important. See instructions on back of certificates.

Cor.—12-9-26—A Co.—200 Blks.

E 19388

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

179 E 19388

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. St Joseph Hospital St. 8-17 Ward)

2-FULL NAME Mary E. Schackert

(a) RESIDENCE NO. 1810 N. Durham St St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | white | widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Schackert

6 DATE OF BIRTH (month, day, and year) Feb 22/1878

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 49 | 0 | 1 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) At home.

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Thomas Sapp

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Margaret Schmidt

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Germany

14 Informant Fred Schackert

(Address) 1805 N. Durham St

15 Filed FEB 25 1927 19 FRANCIS JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 23/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Burns over Face, Arms & body. Fell over oil stove in residence.

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) [signature] M. D.

(Coroner)

2/24/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?_____

Former or usual residence_____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery Date of Burial 2/25 1927

20 UNDERTAKER George J. Ruth ADDRESS 1735 Hanford

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 19389 — CERTIFICATE OF DEATH — Hillsdale — 90 — E 19389 REGISTERED NO.

City of BALTIMORE: (No. Winston Mill Rd. St. 28-65 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Grace Everhart

(a) RESIDENCE NO. Winston Mill Rd St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female — 4 Color or Race: white — 5 Single, Married, Widowed, or Divorced, (write the word): married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Dr. Geo. Y. Everhart

6 DATE OF BIRTH (month, day, and year) August 12, 1869

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 57 | 6 | 10 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town): Md.
(State or country)

PARENTS

10 NAME OF FATHER Geo. W. Ebaugh

11 BIRTHPLACE OF FATHER (city or town):
(State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Eichler

13 BIRTHPLACE OF MOTHER (city or town):
(State or country) Md.

14 Informant Dr. Geo. Y. Everhart
(Address) Winston Mill Rd

15 Filed ..... 19..... Registrar

AUG 25 1927

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 22, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart disease

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs. mos. ds.

(Signed) J. F. Heuisler M. D.
(Coroner)

(Address) 2 E Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Park Cemetery — Date of Burial Feb 25 1927

20 UNDERTAKER: John F. Denny — ADDRESS 715 Light St

If very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

Jr Stockin Drummond Ave

# HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

## CERTIFICATE OF DEATH

90 E 19390

19390

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE, (No. 3902 Old York Rd St., 9-47 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph N. Storkey

(a) RESIDENCE NO. 3902 Old York Rd St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret A. Storkey

6 DATE OF BIRTH (month, day, and year): Dec 8 1856

7 AGE: Years 70 Months 2 Days 15

IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Butcher, retired

(b) General nature of Industry, business, or establishment in which employed (or employer): 013

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country): Md

PARENTS

10 NAME OF FATHER: Jonas N Storkey

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Pa.

12 MAIDEN NAME OF MOTHER: Catherine Roberts

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Pa

14 Informant: Margaret A Storkey

(Address): 3902 Old York Rd

15 Filed FEB 25 1927 19

C. HAMPSON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 23 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 20, 1927, to Feb. 23, 1927.

that I last saw h. m. alive on Feb. 22, 1927.

and that death occurred, on the date stated above, at 11 20 A. m.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency

Am not able to state duration

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Acute Bronchitis

(duration) about one week yrs. mos. ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. D. Staerkin, M. D.

2/24/1927 (Address) 3949 Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine

Date of Burial: Feb 26 1927

20 UNDERTAKER: J. H. Cook

ADDRESS: 507 E Baltimore

Be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 19391

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

100-001

REGISTERED NO. E 19391

1-PLACE OF DEATH Mercy Hospital

City of BALTIMORE: (No. ..... St. 27-56 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Fritz

(a) RESIDENCE NO. 4718 Park Heights Ave Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced BUSBAND of (or) WIFE of: Lydia Fritz

6 DATE OF BIRTH (month, day, and year): Aug 31, 1858

7 AGE — Years: 68 | Months: 8 | Days: 25 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shoemaker None

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: Self

9 BIRTHPLACE (city or town): .....

(State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town): .....

(State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): .....

(State or country): Unknown

14 Informant: Lydia Fritz

(Address): 4718 Park Heights Ave

15 Filed ..... 19 ..... C. HAMILTON JONES, M. D. Registrar

25 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 24 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb. 20, 1927, to Feb 24, 1927, that I last saw h.. alive on Feb. 24, 1927, and that death occurred, on the date stated above, at 3:15 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Senility

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? .....Date of.....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) E. Mowbray, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — Date of Burial: Feb 26 1927

20 UNDERTAKER: W. M. Cook — ADDRESS: 502 E. Monument

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 19392

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 19392
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Kennedy Hosp. St. 4-25-185 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hamid Thompson

(a) RESIDENCE NO. 247 N Fayette St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eliza Thompson

6 DATE OF BIRTH (month, day, and year) Apr 16, 1860

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 66 | 9 | 7 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Elevator Operator

(b) General nature of Industry, business, or establishment in which employed (or employer) Stores Co. 86

(c) Name of employer

9 BIRTHPLACE (city or town) Va

(State or country)

PARENTS

10 NAME OF FATHER Barry Thompson

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER Clara

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant John Russell

(Address) 1117 N Bath St

Filed ..... 19..... C. HAMPSON JONES, M. D.

B 25 1927 By ..... Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Accidental Fall on Sidewalk

Fractured Skull with intracranial hemorrhage (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Hamid P Jones M. D.
(Coroner)

, 19 (Address) 3325 Pall Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ..... mos., ..... ds. In the State ..... yrs., ..... mos., ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Loudon Park Hamilton Feb 25 1927

20 UNDERTAKER ADDRESS

H. M. Cook 502 E Lafayette Ave

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19393

## CERTIFICATE OF DEATH.

X 11-001

E 19393
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 146 W Preston ST. 11-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raymond Harrison

(a) RESIDENCE NO. 146 W Preston ST., WARD Virginia
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | Colored | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 1, 1924

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 2 | | 23 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Richard Harrison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Lizzie Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Father Harrison
(Address) 146 Preston St

15 Filed Feb 25 1927, 19... C. HAMPSON JONES, M. D. Registrar
Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 24th 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 20th, 1927, to Feb. 24, 1927, that I last saw h[illegible] alive on Feb 22d, 1927, and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia

(duration) yrs. mos. 7 ds.
CONTRIBUTORY (Secondary) Influenza Septic

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

Signed R. Lee Elliott, M. D.
Address 1427 92 Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Calvary Cem — DATE OF BURIAL Feb 25, 27

20 UNDERTAKER Dr. R. A. Elliott — ADDRESS 1727 Madison Ave

HOW IS VERY important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 1935 45

## CERTIFICATE OF DEATH.

27-43 REGISTERED NO. E 19394

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3 Edgewood Ave ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William F. Dinan

(a) RESIDENCE NO. 3 Edgewood Ave. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~over~~ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Kernan

6 DATE OF BIRTH (month, day, and year) unknown

| 7 AGE | Years | Months | Days | If LESS than 1 day, ...hrs. or ...min. |
|---|---|---|---|---|
| | 53 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Builder

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Fred. Co. Md.

PARENTS

10 NAME OF FATHER Morris Dinan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Nora Riordan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Jos. Dinan

(Address) 1321 Hura St.

15 2 5 1927 C. HAMPSON JONES, M. D. Registrar

Per OK.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-25-27

17 I HEREBY CERTIFY, That I attended deceased from 2-16, 19 27, to 2-22, 19 27.

that I last saw h alive on 2-22, 19 27

and that death occurred, on the date stated above, at 5 1 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Intestines

Liver - Ulcerated

Peritonitis

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X-ray

(Signed) J. Rhig Rituda M. D.

2-24-27 (Address) 100 N Bath Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral DATE OF BURIAL Feb. 26 1927

20 UNDERTAKER Rita Wredefeld ADDRESS 914 Greenmount Ave

IMPORTANT. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19395

## CERTIFICATE OF DEATH.

129

E 19395

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 310 N. Vincent ST. 19-27 WARD)

2-FULL NAME Doretha Forrest

(a) RESIDENCE NO. 310 N. Vincent ST., ..... WARD .....

(Usual place of abode) dont (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Colored | Married |

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Claude Forrest

6 DATE OF BIRTH (month, day, and year) March 31-1881

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 45- | 10 | 22 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) Private Laundry Work

(c) Name of employer Different families

9 BIRTHPLACE (city or town) Annapolis (State or country) Maryland.

PARENTS

10 NAME OF FATHER John W. Brown

11 BIRTHPLACE OF FATHER (city or town) Annapolis (State or country) Maryland

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) Annapolis (State or country) Maryland

14 Informant Claude Forrest (Address) 310 N. Vincent St.

15 Filed FEB 25 1927 H. HAMPSON JONES, M. D. Registrar Per

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 22- 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 19- 1927, to Feb. 22- 1927, that I last saw her alive on Feb. 22- 1927, and that death occurred, on the date stated above, at 11-P. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

last 6 months (duration) - yrs. 6 mos - ds.

CONTRIBUTORY (Secondary) not definitely known (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Chas. C. McCarthy M. D.

19 (Address) 2410 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL Feb 26th 1927

20 UNDERTAKER A. Jones — ADDRESS, W. L. Gilman

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19396
1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

2-27 100-001

E 19396
REGISTERED NO.

City of BALTIMORE. (No. 209 N. Parrish Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Mack.

(a) RESIDENCE NO. 209 N. Parrish Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 Color or Race: Cold
5 Single, Married, Widowed, or Divorced, (write the word): married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Carrie Mack

6 DATE OF BIRTH (month, day, and year): May 25 1878

7 AGE: Years 48 Months 8 Days 29 IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Shucster
(b) General nature of industry, business, or establishment in which employed (or employer): 045
(c) Name of employer

9 BIRTHPLACE (city or town): Balto
(State or country)

PARENTS

10 NAME OF FATHER: Richd Mack
11 BIRTHPLACE OF FATHER (city or town): Md
(State or country)
12 MAIDEN NAME OF MOTHER: Lucindy Boggs
13 BIRTHPLACE OF MOTHER (city or town): Md
(State or country)

14 Informant: Carrie Mack
(Address): 209 N Parrish St

FEB 25 1927

C. HAMPSON JONES, M. D.
Per ..... Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month) Feb (day) 24 (year) 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, Autopsy or Inquiry)
thereon and from the evidence obtained ... Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) 4 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Heart Failure

(Duration) ... yrs. ... mos. ... ds.

(Signed) Thos. B. Horton M. D.
Coroner

Feb 24 1927 (Address) Curtis Bay, Md

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem
Date of Burial: Feb 28th 1927

20 UNDERTAKER: W. S. Gibson
ADDRESS: 111 S. Gilmor St.

very important. See instructions on back of certificate.

Spec. -7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19397

## CERTIFICATE OF DEATH

161-001

E 19397

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. St Agnes Hospital St. 25-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Fuhrman

(a) RESIDENCE NO. Towson - Md St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 24 - 1927

7 AGE ~~Years~~ ~~Months~~ ~~Days~~ 1 Hour 55 Minutes

IF LESS than ~~1 day~~ 1 hrs. or 55 min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General natore of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) St Agnes Hospital

(State or country)

PARENTS

10 NAME OF FATHER Henry J. Fuhrman

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Edna K. Fisher

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Pennsylvania

14 Informant Henry J Fuhrman

(Address) Towson Md.

15 Filed MAR 25 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 24 - 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Feb 24, 19 27 to Feb 24, 19 27

that I last saw her alive on Feb 24, 19 27

and that death occurred, on the data stated above, at 12.40 P m.

The CAUSE OF DEATH* was as follows:

PREMATURITY - 7 [illegible]

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? PHYSICAL FINDINGS

(Signed) [illegible] M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Date of Burial Feb. 25 19 27

20 UNDERTAKER Horace H. Burgee ADDRESS 243 Fallsld.

very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

E 19398

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

101-001

E 19398

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3329 Alto Ave. St. 15-61 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mina J. Stewart

(a) RESIDENCE NO. 3329 Alto Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm Yates Stewart

6 DATE OF BIRTH (month, day, and year): Jan. 1860

7 AGE: Years 67 Months 1 Days

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): ?

(State or country): Va

PARENTS

10 NAME OF FATHER: ? Lyzotte

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Va

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Va

14 Informant: Mr. Robert N. Soulsby

(Address) 3329 Alto Ave.

FEB 25 1927

C. HAMPSON JONES, M. D.

Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 23 19 27

17 I HEREBY CERTIFY, That I attended deceased from Feb 17, 1927, to Feb 23, 1927, that I last saw her alive on Feb 23, 1927, and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 1 yrs. 1 mos. 6 da.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart (duration) ✓ yrs. ✓ mos. ✓ da.

18 Where was disease contracted if not at place of death? Place of Death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys. Exam.

(Signed) John A. Graham M. D.

2/25. 1927 (Address) 1219 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem. Date of Burial: Feb. 25 1927

20 UNDERTAKER: Wm J. Tickner & Sons ADDRESS: Mount Pa

very important. See instructions on back of certificates.

...ecessary, so that a ... may be properly classified. Each statement of OCCUPATION is

Spec—12-23-21—E.B.R.S.—400 Eks.

E 19399

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

100-001

E 19399

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE, (No. 1410 Rutter St., 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Christine Harris

(a) Residence No. 1410 Rutter St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 3 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3-SEX Fe

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Nov. 21. 1925

7-AGE. 1 yrs. 3 mos. 3 ds. If LESS than 1 day, ....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9-BIRTHPLACE (city or town) (State or Country), Baltimore City Md

PARENTS:

10-NAME OF FATHER, Broggie Harris

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Sarah Harris

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Virginia

14- (Informant) Broggie Harris

(Address) 1410 Rutter St

15- 2 1927 E. HAMPSON JONES, M. D. Registrar.

Per [illegible]

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 24. 1927

17- I HEREBY CERTIFY, That I attended deceased from Feb 22, 1927, to Feb 23 1927.

that I last saw h— alive on Feb 22 1927.

and that death occurred on the date stated above, at 3:40 A m.

The CAUSE OF DEATH* was as follows:

(a) Bronchopneumonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) R. Garland Schmidt M. D.

2-24. 1927 (Address) 1534 E. H. St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn DATE OF BURIAL: Feb 26. 1927

20-UNDERTAKER: Hunt Easter ADDRESS 916 E. Lanvale St

INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 19400 PLACE OF DEATH

REGISTERED NO. E 19400

CITY OF BALTIMORE: (No. 1715 Poplar Grove ST. 15-68 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Eunice Norris

(a) RESIDENCE No. 1715 Poplar Grove ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Dr. Jacob L. Norris

6 DATE OF BIRTH (month, day, and year): July 1855

7 AGE — Years: 71 — Months: 7 — Days: — If LESS than 1 day, hrs or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Frederick Co. Md.

PARENTS

10 NAME OF FATHER: Garrison Warfield

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Caroline Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs. Jessie Roxbrough
(Address) 1715 Poplar Grove

15 Filed FEB 25 1927 for C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 24, 1927

17 I HEREBY CERTIFY That I attended deceased from Jan 1, 1926, to Feb 24, 1927.

that I last saw h[illegible] alive on Feb 23 about, 1927.

and that death occurred, on the date stated above, at 6a m.

The CAUSE OF DEATH* was as follows:

arteris-salerosis — High Blood pressure — myocarditis

Chronic-interstitial nephritis — ?

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage + paralysis about 12h

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wat S Nesbitt M. D.

2/26/27 (Address) 2220 Harrison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemy. DATE OF BURIAL: Feb. 26 1927

20 UNDERTAKER: John C. Mitchell ADDRESS: 1900 Eutaw Pl.

THIS is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 19401 HEALTH DEPARTMENT—CITY OF BALTIMORE E 19401

# CERTIFICATE OF DEATH.

1-PLACE OF DEATH Franklin Square Hosp. REGISTERED NO. 14710 94-0

CITY OF BALTIMORE: (No. 1 ST., 1 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lambin Bayles

(a) RESIDENCE NO. 1716 John ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | Widower |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 13, 1850

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or min. |
|---|---|---|---|---|
| | 76 | 5 | 11 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired, Penna RR
(b) General nature of industry, business, or establishment in which employed (or employer) 073
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Bernard Bayles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Elizabeth Banning

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Charles F. King
(Address) 901 West Wilmington, Del.

15 Filed AUG 25 1927 19 C. HAMPSON JONES, M. D. Registrar
By R K

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-24 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 19, 1927, to Feb. 24, 1927, that I last saw him alive on Feb. 24, 1927; and that death occurred, on the date stated above, at 9.30 A. m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
Hemiplegia
Arterio-Sclerosis.
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Francis L. Sedgwick M. D.

, 19 (Address) Franklin Sq. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemy. DATE OF BURIAL Aug. 26 1927

20 UNDERTAKER John O. Mitchell ADDRESS 1900 Eutaw Place

TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 19402

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90

E 19402

REGISTERED NO.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St. 69 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Carback.

(a) RESIDENCE NO. 1904 Orleans St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widowed |

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of late Richard Carback

6 DATE OF BIRTH (month, day, and year) Sept 5/ 1860

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 66 | 5 | 19 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer at Home

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Louis Wolff

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Minnie Nurnberg

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 BALTIMORE CITY HOSPITALS

Informant

(Address) [redacted]

Filed 19

C. HAMPSON JONES, M. D.

Registrar

B 25 1927 Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 24 1927

17

I HEREBY CERTIFY, That I attended deceased from February 21, 1927, to February 24, 1927, that I last saw h.. alive on February 23, 1927, and that death occurred, on the date stated above, at 7 30 A m.

The CAUSE OF DEATH* was as follows:

myocardits, chronic - acute arteriosclerosis, hypertension

0 existing

(duration) yrs. 1 mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? General Laboratory

(Signed) R. Harper Small M. D.

Feb 24 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| St. Mathews | 2/26 1927 |
| 20 UNDERTAKER | ADDRESS |
| Philip Herwig | 2016 Orleans St. |

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 19403

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19403

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2502 E: Preston St ST. 8-16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Frederick Barrett

(a) RESIDENCE No. 2502 E: Preston St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 7 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX ~~Female~~ Male.

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 27 th 1926

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or min. |
|---|---|---|---|---|
| | | 7 | 28 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Fredk L: Barrett

11 BIRTHPLACE OF FATHER (city or town) Pierre (State or country) North Dakato

12 MAIDEN NAME OF MOTHER Anna M: Fricke

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Fredk L: Barrett

(Address) 2502 E: Preston st

15 Filed FEB 25 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 24 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 27 1926 to Feb 24 1927 that I last saw h[illegible] alive on Feb 24 1927 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

(Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem

DATE OF BURIAL Feby 26 27

UNDERTAKER John Ullrick

ADDRESS 2008 Aliceanna

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

Holland

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19404

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Pronounced dead at St. Joseph Hospital St. 6-10 Ward)

2-FULL NAME Charles Holland

(a) RESIDENCE NO. 405 N. Luzerne Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. 6 mos. 2 ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

1886-003

E 19404

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 21st 1919

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 7 | 6 | 2 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work school boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto, Md

PARENTS

10 NAME OF FATHER Wm. Holland

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Somerset Co, Md

12 MAIDEN NAME OF MOTHER Effie Mills

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Mr Wm Holland

(Address) 405 N. Luzerne Ave

15 Filed 1927 C. HAMPSON JONES, M. D.

Registrar

B 25 1927

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 23/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Crushed head) run over by auto truck at Lakewood and Fayette Accidental

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. J. Collins M. D.

(Coroner)

2/24/27 (Address) 508 e. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fairmount Md — Date of Burial Feby 26 27

20 UNDERTAKER John Leerick — ADDRESS 20 Orleans

Very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

SKINNER

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19405

## CERTIFICATE OF DEATH.

101-001

E 19405

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 700 W Fairmount St. 14-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jane Skinner

(a) RESIDENCE NO. 700 W Fairmount St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | Col | Sing'l |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| About 31 | | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer (Col)

(b) General nature of industry, business, or establishment in which employed (or employer) Not known

(c) Name of employer

9 BIRTHPLACE (city or town) Unknown

(State or country)

PARENTS

10 NAME OF FATHER John Skinner

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Johnson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Sarah Mary

(Address) 109 Arch St

FEB 25 1927

C. HAMPSON JONES, M. D.

Registrar

Per

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-22 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Hamilton Drake M. D.

(Coroner)

, 19 (Address) 3326 Bid Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary Cy Date of Burial Feb 25, 1927

20 UNDERTAKER Leonard Wheeler ADDRESS 308 Myrtle Ave

Mt Calvary

very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19406

## CERTIFICATE OF DEATH.

E 19406

15-60 (101 001 ✓

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1606 Ashburton St., WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Vorlaufer

(a) RESIDENCE NO. 1606 Ashburton ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 10, 1925

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 1 | 10 | 14 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John G. Volaufer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Elizabeth Hamilton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Winnepeg, Canada.

14 Informant John G. Volaufer
(Address) 1606 Ashburton St.

Filed FEB 25 1927 HAMPSON JONES, M. D. Registrar

By .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 24, 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 8, 1927 to Feb. 23, 1927 that I last saw him alive on Feb. 23, 1927 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pneumonia (lobar)

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw. Hambleton, M. D.

2/25, 1927 (Address) 24 N. Fulton Ave..

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Snicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| New Cathedral Cemetery | Feb 26 1927 |
| 20 UNDERTAKER | ADDRESS |
| Robt J Turner Sr | 1772 E Broadway |

Spec.—1-10-21—M&T—1500 Bks.

Wm Carey Freeland.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19407

## CERTIFICATE OF DEATH.

11-802

E 19407

15-63

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3705 Sequoia Ave., ..... WARD)

2-FULL NAME Wm Carey Freeland

(a) RESIDENCE NO. 3705 Sequoia Ave., ..... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | — |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 3, 1920

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 6 | 7 | 21 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Fayette F. Freeland

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Md.

12 MAIDEN NAME OF MOTHER Carrie Foster

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Md.

14 Informant F. F. Freeland
(Address) 3705 Sequoia Ave.

15 Filed AUG 25 1927 .19.... C. HAMPSON JONES, M. D.
Per ..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby. 24, 1927

17

I HEREBY CERTIFY, That I attended deceased from Jany. 24 .1927. to Feby. 24 .1927.
that I last saw him alive on Feby. 24 .1927.
and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

meningitis

(duration) yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) grip

(duration) yrs. ..... mos. 32 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical signs & symptoms

(Signed) L. F. Shamwell M. D.

.19.... (Address) 3310 Tioga Parkway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemt

DATE OF BURIAL Feb 26 1927

UNDERTAKER Kirkland Moore

ADDRESS 1723 W Lafayette Ave

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19408

## CERTIFICATE OF DEATH.

38 E 19408

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 312 N. Gilmor St. 9-27 Ward)

2-FULL NAME William Johnson

(a) RESIDENCE NO. 312 N. Gilmor St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col'd

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown 1893

7 AGE: Years: About 34 Months: — Days: — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Ship's Cook

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) British West Indies Islands

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) British West Indies

12 MAIDEN NAME OF MOTHER Mary Sebastian

13 BIRTHPLACE OF MOTHER (city or town) St. Kitts

(State or country) West Indies Islands

14 Informant (Address) Donald Duncan 2020 McCulloh St.

Filed FEB 25 1927 C. HAMPSON JONES, M. D. Registrar

Per

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22nd 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Coroner, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

Unknown

CONTRIBUTORY (Secondary) Possibly Syphilis

(Signed) Thos. B. Horton M. D.

(Corner)

Feb 24 1927 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or in Violent Cases, Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

In this city, town or county yrs. mos. ds. In the State yrs. mos. ds.

(Where was disease contracted, if not at place of death?)

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. Date of Burial 2/26 1927

UNDERTAKER Samuel L. Hensley ADDRESS 518 N. Eden St.

very important. See instructions on back of certificate. LAST BIRTHDAY OF OCCUPATION is

Spec. 1-10-21 M&T 1500 Blks.

E 19409

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19409

## CERTIFICATE OF DEATH.

94-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1359 Carroll ST. 21-29 WARD)

2-FULL NAME Mosiah Green

(a) RESIDENCE NO. 1359 Carroll ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 ~~Single~~, Married, Widowed, or ~~Divorced~~, (write the word): Widower

6a If married, widowed, or divorced: (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1852

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 75 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Iron Worker

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: James Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant (Address): John W. Lewis 1359 Carroll Street

15 2 5 1927 C. HAMPSON JONES, M. D. Registrar

Par

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2-23-1927

17 I HEREBY CERTIFY, That I attended deceased from 2-20, 1927, to 2-23-, 1927

that I last saw him alive on 2-23-, 1927

and that death occurred, on the date stated above, at 20 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Alfred Drain M. D.

, 19 (Address) 1359 Carroll Sty

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cemetery — DATE OF BURIAL: 2/26 1927

20 UNDERTAKER: Walter B. Spriggs — ADDRESS: 1394 W. Hamburg St.

TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19410 E 19410

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO. 26-37 90

City of BALTIMORE: (No. [redacted] St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Smith

(a) RESIDENCE NO. BALTIMORE CITY HOSPITALS St. Ward

(Usual place of [redacted] (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1867

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 60 | | | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Germany

PARENTS

10 NAME OF FATHER Bonhert Smith

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine —

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant [redacted]
(Address) [redacted]

15 FEB 25 1927 C. HAMPSON JONES, M. D.
Per [redacted] Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 24 1927

17
I HEREBY CERTIFY, That I attended deceased from February 20, 1927, to February 24, 1927,
that I last saw him alive on February 24, 1927,
and that death occurred, on the date stated above, at 5:45 A m.

The CAUSE OF DEATH* was as follows:
Arterial Sclerosis
Chronic Myocarditis & Insufficiency
(duration) yrs. mos. ds.

CONTRIBUTORY Bronchopneumonia
(Secondary)
(duration) yrs. mos. 3 ds.

18 Where was disease contracted
If not at place of death]
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? general laboratory
(Signed) A. Hooper Smith, M. D.
Feb 24 19 Address BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

NS HOPKINS HOSPITAL
Commissioner Health.
FEB 25 1927

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

**E 19411** ✓ **E 19411**

## CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospitals 5-8 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Taylor

(a) RESIDENCE NO. 1304 Mulliken St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | Col. | M. |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1851

| 7 AGE Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|
| 76 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ga

(State or country)

PARENTS

10 NAME OF FATHER John Jackson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ga

12 MAIDEN NAME OF MOTHER Mary Elizabeth ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ga

14 Informant

(Address)

15 Filed 1927 16 C. HAMPSON JONES, M. D. Registrar 4080

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 Feb. 22, 27

17

I HEREBY CERTIFY, That I attended deceased from 2-10, 1927, to 2-22, 1927

that I last saw h[illegible] alive on 2-22, 1927

and that death occurred, on the date stated above, at 11 30 a.m.

The CAUSE OF DEATH* was as follows:

Bilateral, Pulmonary Tuberculosis

[illegible] mos., ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) Eugene [illegible] M. D.

, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

JOHNS HOPKINS HOSPITAL

20 UNDERTAKER — ADDRESS

Commissioner Health.

FEB 25 1927

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19412

## CERTIFICATE OF DEATH.

15-21 161-001

E 19412

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 1511 Presstman St. St. 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Higgs

(a) RESIDENCE NO. 1511 Presstman St. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: C

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2-22-27

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | | | 2 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of Indastry, business, or establishment in which employed (or employer) Old

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER George Higgs

11 BIRTHPLACE OF FATHER (city or town) Balto.

(State or country) Md

12 MAIDEN NAME OF MOTHER Beulah V. Buchanan

13 BIRTHPLACE OF MOTHER (city or town) Balto Co

(State or country) Md

14 Informant Elsie Buchanan

(Address) 1511 Presstman St

15 Filed _____, 19____ C. HAMPSON JONES, M. D. Registrar

FEB 25 1927 Per 1078 CPM

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 24, 1927 19

17

I HEREBY CERTIFY, That I attended deceased from Feb 22 19 27, to Feb 24 19 27, that I last saw her alive on Feb 24 19 27, and that death occurred, on the date stated above, at 12:30 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth

6½ months

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Marcellus T. Jones, M. D.

, 19 (Address) 1445 N. Carey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

JOHNS HOPKINS HOSPITAL

Commissioner Health.

FEB 25 1927

For Wm. S. KOSSALL

Very important. See instructions on back of certificates.

Spec.—12 9 25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

**E 19413**

## CERTIFICATE OF DEATH.

16 E 001 **E 19413**

12-19

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 415 E Federal St. St. 12 Ward)

2-FULL NAME Baby Scott

(a) RESIDENCE NO. 415 E Federal St Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | aa | Single |

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 24 1927

| 7 AGE | Years | Months | Days | IF LESS than 1 day ~~1 hr.~~ or 20 min. |
|---|---|---|---|---|
| ns | 00 | 00 | 00 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ns ns

(b) General nature of industry, business, or establishment in which employed (or employer) ns

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER William Scott

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Emma Spann

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant

(Address)

_____ 19 _____ Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 24 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 24, 1927, to Feb 24, 1927, that I last saw ~~him~~ alive on Feb 24, 1927, and that death occurred, on the date stated above, at 10 55 a. m.

The CAUSE OF DEATH* was as follows:

Asphyxia caudalon of Prematurity and premature Birth

(duration) ____ yrs. 0 mos. 1 ds.

CONTRIBUTORY (Secondary) Premature Birth

(duration) ____ yrs. 0 mos. 1 ds.

18 Where was disease contracted

If not at place of death? Ambulance

Did an operation precede death? no Date of no.

Was there an autopsy? no

What test confirmed diagnosis? Asphyxia Lividus

(Signed) G. F. Hall, M. D.

, 19 (Address) 426 E 23 d St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

Date of Burial FEB 25 1927

20 UNDERTAKER (Not Commissioner Health.)

ADDRESS

J. C. HAMPSON JONES, M. D.

Filed 19 Per

1075

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001

E 19414

## CERTIFICATE OF DEATH.

E 19414

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 415 E. Federal St. St. 12-19 Ward)

2-FULL NAME Baby Scott

(a) RESIDENCE NO. 415 E. Federal St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: aa

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 24, 1927

7 AGE — Years: 00 — Months: 00 — Days: 00 — IF LESS than 1 day ..hrs. or ..min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER William Scott

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Emma Spencer

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant

(Address)

15 Filed ..., 19 C. HAMPSON JONES, M. D. Registrar

FEB 25 1927

1076

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 Feb. 24

17 I HEREBY CERTIFY, That I attended deceased from Feb 24, 1927, to Feb 24, 1927, that I last saw h... alive on Feb 24, 1927, and that death occurred, on the date stated above, at 11.45 p m.

The CAUSE OF DEATH* was as follows:

Asphyxia Cyanotica Neonatorum and Premature Birth

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Premature Birth

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Asphyxia Cyanotica

(Signed) J. F. Hall, M. D.

, 19 (Address) 4264 Reisterstown Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

JOHNS HOPKINS HOSPITAL 19

20 UNDERTAKER — ADDRESS

Commissioner Health. FEB 25 1927

very important. See instructions on back of certificate. EARLY STATEMENT OF OCCUPATION IS

Spec.—1-10-21—M&T—1500 Bks.

(Snyder)

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19415

E 19415

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Maryland General Hospital 100-007

CITY OF BALTIMORE: (No. Linden Ave. & Madison ST. 28-65 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert F. Snyder

(a) RESIDENCE NO. 36 Forrest park Ave ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 1st 1925

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 1 | 7 | 23 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Hillsdale
(State or country) Md

PARENTS

10 NAME OF FATHER Joseph L. Snyder

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Carroll Co. Md

12 MAIDEN NAME OF MOTHER Agnes E. Stauffer

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Carroll Co Md

14 Informant Mrs. Joseph L. Snyder
(Address) 36 Forrest Park Ave.

15 Filed ..... 19..... Registrar

FEB 25 1927 HAMPSON JONES Jr. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 24 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 31 1927 to Feb 24 1927, that I last saw him alive on Feb 24 1927, and that death occurred, on the date stated above, at 8 55 P m.

The CAUSE OF DEATH* was as follows:

Chronic Otitis Media

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Peritonitis 1 mo 15 days
Bronco Pneumonia
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 2-1-27 OWN

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno A Hampton M. D.

Address 1 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Lorraine Park Cem | Feb. 28th 1927 |
| 20 UNDERTAKER Joseph B. Cook | ADDRESS 1003 N Eutaw |

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 19416 — 11-2474001 — E 19416

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 928 W. Cullob St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Justice Lee

(a) RESIDENCE NO. 928 W. Cullob St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | Unknown. |

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1858

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 69 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work automobile mechanic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Morris Garage Co.

9 BIRTHPLACE (city or town) Louisville

(State or country) Ky

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Preston Lindsay

(Address) 928 W. Cullob St.

15 Filed ..... 19 .....

J. C. HAMPSON JONES, M. D.

Per ..... Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 19 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) No history

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D.

(Coroner)

2/19, 192 (Address) 2812 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Cem. Date of Burial 2/24/27

20 UNDERTAKER Mrs. R. G. Elliott ADDRESS 1725 E. Baltimore

very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

E 19417

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19417

## CERTIFICATE OF DEATH

31

1-PLACE OF DEATH Colonial Hospital REGISTERED NO.

City of BALTIMORE: (No. 1122 No. Monroe St. 22-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Height

(a) RESIDENCE NO. 176 Thos St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE 34 Years 33 Months Days IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Calvert Co. Md.

(State or country)

PARENTS

10 NAME OF FATHER George Height

11 BIRTHPLACE OF FATHER (City or town) Calvert Co. Md.

(State or country)

12 MAIDEN NAME OF MOTHER Carrie Smith

13 BIRTHPLACE OF MOTHER (city or town) D. C.

(State or country)

14 Informant Edith Gross

(Address) 914 S. Eutaw st.

15 Filed C. HAMPSON JONES, M. D.

2 5 1927 Per R.R.S. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/23 1927

17 I HEREBY CERTIFY, That I attended deceased from 2/12, 1927 to 2/23, 1927

that I last saw h[illegible] alive on 2/23/27, 19

and that death occurred, on the data stated above, at 11.55 A m.

The CAUSE OF DEATH* was as follows: Pulmonary tuberculosis.

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of 2/12/27

Was there an autopsy? No

What test confirmed diagnosis? Sputum & tuberculosis

(Signed) John W. Graham M. D.

19 (Address) Colmar Manor, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Calvert about Carroll County — Date of Burial Feb. 27 1927

20 UNDERTAKER R. L. Partham — ADDRESS 1216 N. Sharp st.

very important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19418

E 19418

## CERTIFICATE OF DEATH

101-001

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1416 N Sharp St. 23-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Robb

(a) RESIDENCE NO. 1416 N Sharp St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 4 mos. 25 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | C | Infant |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 25 1925

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 1 | 4 | 25 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Edmund Robb

11 BIRTHPLACE OF FATHER (City or town) Essex Co

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Virginia Harris

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant Virginia Robb

(Address) 1416 N Sharp

15 Filed FEB 25 1927 C. HAMPSON JONES, M. D. Registrar

Per RRH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) FEB 23 1927

17 I HEREBY CERTIFY, That I attended deceased from 2/17, 1927, to 2/23, 1927.

that I last saw her alive on 2/23, 1927.

and that death occurred, on the date stated above, at 11 35 P. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

Primary (duration) — yrs. — mos. 13 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted —

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) David Francisco M. D.

2/23 1927 (Address) 1422 E Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion

Date of Burial Feb 26 1927

20 UNDERTAKER R E Parham

ADDRESS 1216 N Sharp St

FEB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE
OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is
very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 19419

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

74-001 E 19419

8-17

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 1619 N. Dallas St St._____ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Benj. T. Hoke

(a) RESIDENCE NO. 1619 N. Dallas St St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | col | widow er |

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Jeanette Hoke

6 DATE OF BIRTH (month, day, and year) Aug 10/1868

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 58 | 6 | 15 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Harforf Co., Md

PARENTS

10 NAME OF FATHER Jacob Hoke

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Harforf Co., Md

12 MAIDEN NAME OF MOTHER Susan Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Harford Co., Md.

14 Informant Isabelle Danze

(Address) 1619 N. Dallas St

15 Filed 5 1927 By C. HAMPSON JONES M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25/27 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Apoplexy

(Paralyzed since Sept /26)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Undetermined

(duration) yrs. mos. ds.

(Signed) J. T. Yates M. D.

(Coroner)

2/25/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Union M. E. Cemetery Harford Co Md Date of Burial Feb 26 1927

20 UNDERTAKER Henry Tarring Jones ADDRESS Chestertown Md

very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 19420 HEALTH DEPARTMENT—CITY OF BALTIMORE E 19420

CERTIFICATE OF DEATH.

76-37 101-06

1-PLACE OF DEATH

City of BALTIMORE: (No. 628 S. Fifth St.) (Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Bartulis

(a) Residence No. 628 S. Fifth St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Bartulis

6-DATE OF BIRTH (month, day and year) Aug 11 1884

7-AGE. 42 yrs. 5 mos. 12 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Labor

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Lithuania

PARENTS.

10-NAME OF FATHER, Machael Bartulis

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Lithuania

12-MAIDEN NAME OF MOTHER, Mary Mantus

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Lithuania

14- (Informant) Mary Bartulis

(Address) 628 S. Fifth St.

15- Filed 1927 C. HAMPSON JONES, M. D. Registrar.

Per

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 23 1927

17- I HEREBY CERTIFY, That I attended deceased from 2/20/27, 19..., to 2/23, 1927, that I last saw him alive on 2/23, 1927, and that death occurred, on the date stated above, at 6:15 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Intoxication

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. C. Garell M. D.

2/26, 1927 (Address) 635-S-St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: St Matthew's — DATE OF BURIAL: Feb 27, 1927

20-UNDERTAKER: John C Miller — ADDRESS: 2435 E Oliver St

Instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

E 19421

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 19421

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 256 S Dallas ST. 3-4 WARD)

2-FULL NAME Frank Goszinski

(a) RESIDENCE. No. 256 S Dallas ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 3-1926

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | | 3 | 21 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Frank Goszinski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Josephine Krotz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Frank Goszinski

(Address) 25 S Dallas St

15 Filed 2 5 1927

C. HAMPSON JONES, M. D.

Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-24-1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 22 1927, to Feb 23 1927, that I last saw h[illegible] alive on [illegible], 1927, and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia (Primary)

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Same

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jacob L. Weiner, M. D.

(Address) 30 S. Broadway 2-24-1927

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem DATE OF BURIAL 26 1927

20 UNDERTAKER John M. Weber ADDRESS 1803 Bank St

HOW IS VERY important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

E 19422

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19422

## CERTIFICATE OF DEATH

90

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 117 Rochester Place. St. 6-11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Simon Bickel

(a) RESIDENCE NO. 117 Rochester Place. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A. Bickel

6 DATE OF BIRTH (month, day, and year) Mar. 18. 1846

| 7 AGE | Years | Months | Days | IF LESS than 1 day ...hrs. or ...min.. |
|---|---|---|---|---|
| | 80 | 10 | 7 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman 062

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 15 years.

(c) Name of employer N. Gutman.

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Not Known.

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Not Known.

12 MAIDEN NAME OF MOTHER Not Known.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Not Known.

14 Informant Andrew J. Bickel (Son)

(Address) 117 Rochester Place.

25 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 25 1927

17 I HEREBY CERTIFY, That I attended deceased from Feby 1 1927 to Feb 24 1927

that I last saw him alive on Feb 24 1927

and that death occurred, on the date stated above, at 9.30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

2 yrs. mos. ds. (duration)

CONTRIBUTORY (Secondary) Mitral Regurgitation

5 yrs. mos. ds. (duration)

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jos. L. Baker, M. D.

2-25-1927 (Address) 14 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Holy Redeemer Cemetery | Feb. 28 1927 |
| 20 UNDERTAKER | ADDRESS |
| Henry Sander & Sons, Inc. | 1716 Fleet St. |

Be brief in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19423

E 19423

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mercy Hospital

City of BALTIMORE: (No. ____ St., 4-7 Ward)

REGISTERED NO. ____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rev. Fr. Harry B. Sanderson

(a) RESIDENCE NO. Mission Helpers Towson Md. Ward Towson Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Carrie Sanderson

6 DATE OF BIRTH (month, day, and year): 1859

7 AGE: Years 68. Months — Days — IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Religious 65

(b) General nature of industry, business, or establishment in which employed (or employer): Catholic

(c) Name of employer: Priest

9 BIRTHPLACE (city or town): Wisconsin

(State or country)

PARENTS

10 NAME OF FATHER: Chas. Sanderson

11 BIRTHPLACE OF FATHER (city or town): Pokeman

(State or country)

12 MAIDEN NAME OF MOTHER: Ellen Byron

13 BIRTHPLACE OF MOTHER (city or town): Baltimore

(State or country)

14 Informant: Rev. S. E. Smith

(Address) Towson Md.

C. HAMPSON JONES, M. D.

Registrar

2 5 1927 Per ____

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 24 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 28 1927, to Feb 24, 1927, that I last saw h-m alive on Feb 24 1927, and that death occurred, on the date stated above, at 8:30 A. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus c Gangrene

L. of Foot.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary): Cardiac Degeneration

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Feb 22 1927

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. Elliott, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mission Helpers Towson

Date of Burial: 2/28 1927

20 UNDERTAKER: John J. Sabey Sons

ADDRESS 1818 Eutaw St

Be sure that every item is correctly and legibly written. Part Statement of Occupation is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 19424

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19424

## CERTIFICATE OF DEATH.

161-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1125 S. Sharp ST. 23-31 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Terry

(a) RESIDENCE NO. 1125 S Sharp ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2-25-27

7 AGE Years Months Days If LESS than 1 day, hrs. or 40 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None (Ind)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Terry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Alice Tuffetti

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Georgia

14 Informant R. L. Parham

(Address) 1216 Sharp St

15 FEB 6 1927

16 C. HAMPSON JONES, M. D. Registrar

Per Rich

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-25 1927

17

I HEREBY CERTIFY, That I attended deceased from 2-25, 1927, to 2-25, 1927,

that I last saw her alive on 2-25, 1927,

and that death occurred, on the date stated above, at 8 10 P m.

The CAUSE OF DEATH* was as follows:

Congenital atelectasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Breech extraction

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Ernest Dodge, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion

DATE OF BURIAL 2/26 1927

20 UNDERTAKER R. L. Parham

ADDRESS 1216 S Sharp St

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 19425

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19425

## CERTIFICATE OF DEATH.

100-E

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1812 N Chester St ST., 8-17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Andrew Amos.

(a) RESIDENCE NO. 1812 N Chester St ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 27, 1927.

7 AGE: Years | Months | Days 2. | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Brown Amos.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Mary Ellen Long

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs Mary Amos (Address) 1812 N Chester St

15 C. H. HAMPSON JONES, M. D. Registrar

Per RK

2 6 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 24 1927 to Feb 25 1927

that I last saw him alive on Feb 25 1927

and that death occurred, on the date stated above, at 7:10 P. m.

The CAUSE OF DEATH* was as follows:

Broncho pneumia.

(duration) yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) Obstruction

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Bronchoscopic examination

(Signed) Albert Abrahamson M. D.

2/25 1927 (Address) 1025 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem

DATE OF BURIAL Feb 28 1927

20 UNDERTAKER Geo. J. Ruth

ADDRESS 1735 Harford Ave

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# E 19426 HEALTH DEPARTMENT—CITY OF BALTIMORE

90 ✓ E 19426

## CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1744 Harford Ave ST., 9-18 WARD)

2-FULL NAME Paul A Boerschel

(a) RESIDENCE No. 1744 Harford Avenue ST. ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 35 yrs. ..... mos. ..... ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A. Boerschel

6 DATE OF BIRTH (month, day, and year) 12/8/1877

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 49 | 2 | 16 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Piano Polisher 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Steffl Mg Co

9 BIRTHPLACE (city or town) ..... (State or country) Germany

PARENTS

10 NAME OF FATHER August J. Boerschel

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Boerschel

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Germany

14 Informant Mrs Mary Boerschel

(Address) 1744 Harford Avenue

15 Filed 6 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jun 24 1927

17

I HEREBY CERTIFY, That I attended deceased from Dec 19, 1924, to Jun 24, 1927, that I last saw him alive on Jun 24, 1927, and that death occurred, on the date stated above, at 8 A m

The CAUSE OF DEATH* was as follows:

Dilatation of Heart

(duration) ..... yrs. ..... mos 3 ds.

CONTRIBUTORY (Secondary) Chronic Valvular disease of Heart (duration) 15 yrs. 4 mos. 6 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John W. Henderson M. D.

, 19 (Address) 1744 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL 6/28 1927

20 UNDERTAKER George J. Ruth

ADDRESS 1735 Harford Ave

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19427

## CERTIFICATE OF DEATH.

100-001

E 19427

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1607 E. North ave ST., 8-17 WARD)

2-FULL NAME Elizabeth Cruse

(a) RESIDENCE NO. 1607 E. North ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 85 yrs. 6 mos. 17 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elias T.

6 DATE OF BIRTH (month, day, and year) Aug. 8-1841

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 85 | 6 | 17 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) not known

12 MAIDEN NAME OF MOTHER Catharine Bartman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Kunkel

(Address) 1607 E. North ave.

15 Filed 2 6 1927 C. HAMPSON JONES, M. D. Registrar

Per

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 25 1927

17 I HEREBY CERTIFY, That I attended deceased from 2/18, 1927, to 2/25, 1927, that I last saw h[illegible] alive on 2/24, 1927 and that death occurred, on the date stated above, at 1.45 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) George Ames Barden M. D.

2/28, 1927 (Address) 1517 E North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem.

DATE OF BURIAL Feb 28 1927

20 UNDERTAKER Zirkler & Zirkler

ADDRESS 1739 E. Eager st.

Spec.-7-17-26—A Co.—200 Bks.

E·19428

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E·19428

## CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hospital S. 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harold Williams

(a) RESIDENCE NO. 1715 Riggs Ln St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 22 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (write the word) |
|---|---|---|
| M. | Col | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 3-26

| 7 AGE | Years | Months | Days | IF LESS than 1 day ___ hrs. or ___ min.. |
|---|---|---|---|---|
| | | 3 | 22 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~~None~~

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER George A. Williams

11 BIRTHPLACE OF FATHER (City or town) S. C.

(State or country)

12 MAIDEN NAME OF MOTHER Lola Mack

13 BIRTHPLACE OF MOTHER (city or town) S. C.

(State or country)

14 Informant George A. Williams

(Address) 1715 Riggs Ln

15 Filed ___ 19 ___ C. HAMPSON JONES, M. D. Registrar

Per ___

6 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/25/ 1927

17 I HEREBY CERTIFY, That I attended deceased from 2/17/27, 1927, to 2/25, 1927, that I last saw h[illegible] alive on 2/25/, 1927, and that death occurred, on the date stated above, at 12:55 p. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ___ yrs. ___ mos. 1 ds.

CONTRIBUTORY None

(Secondary)

(duration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted if not at place of death? 1715 Riggs Ln.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Course

(Signed) Harold Williams M. D.

2-26 1927 (Address) Colonial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion

Date of Burial 2-28-26 1927

20 UNDERTAKER Sam'l H. Chase Sons

ADDRESS 1400 Madison

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 19429

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

185 E 19429

REGISTERED NO. 2675

1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore General Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Daniel W. Sams.

(a) RESIDENCE NO. 7 S. Fifth St. Brooklyn. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male. | White. | Married. |

5a If married, XXXXXXXXXXXXXX HUSBAND of XXXXXXXXX Sadie A. Sams.

6 DATE OF BIRTH (month, day, and year) September 26, 1881

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 45 | 4 | 27 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Md. Dry Dock Co.

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland.

PARENTS

10 NAME OF FATHER Philip Sams.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Ellen Sherbert.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Do not know.

14 Informant Sadie A. Sams. (wife)

(Address) 7 S Fifth St Brooklyn

2 6 1927, 19 C. HAMPSON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 22, 1927. 193

17 I HEREBY CERTIFY That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull.

Accidental fall down hold of s/s Dauhegan

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) C M Arinhardt M. D.
(Coroner)

2/25, 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death? Md Dry Dock Co. Fairfield. Feb. 20, 1927.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery Co Date of Burial Feb 26 1927

20 UNDERTAKER John F. Denny ADDRESS 715 Light St

very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

19430

## CERTIFICATE OF DEATH.

11-002 E 19430

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 428 E. 22nd St. 17-50 Ward)

2-FULL NAME Sallie Mary Granger

(a) RESIDENCE NO. 428 E. 22nd St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, ~~Married, Widowed,~~ or ~~Divorced~~, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 24 1855

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 71 | 11 | 0 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town)_____

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Mathew James Granger

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Sophia F. Welty

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Emmitsburg, Md.

14 Informant (Address) Maria L. Granger 428 E. 22 St.

15 Filed 2 1927 C. HAMPSON JONES, M. D. Registrar

Per [illegible]

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 February 24th 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 16 1927, to Feb 24 1927, that I last saw h[illegible] alive on Feb 23 1927, and that death occurred, on the date stated above, at 4:45 p.m.

The CAUSE OF DEATH* was as follows:

La Grippe

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Geo. Hampson Jones III M. D.

2/25 1927 (Address) 401 E 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem. Date of Burial 2/26 1927

20 UNDERTAKER: Mary M. Wiedefeld. ADDRESS 501 E. 22 St.

very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

E 19431

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19431 E 36 58 90 8.68

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2803 St Paul St 45-22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia Wallace

(a) RESIDENCE NO. 1373 N Carey St. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas H Wallace

6 DATE OF BIRTH (month, day, and year): Aug 1868

7 AGE: Years 58 | Months 6 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: cook
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: B & O Dennington

9 BIRTHPLACE (city or town) (State or country): Calvert Co Md.

PARENTS

10 NAME OF FATHER: Peter Gross

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Hannah Ennis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs Maud Jones (Address) 1373 N Carey St

15 Filed 2 5 1927, 192. C. HAMPSON JONES, M. D. Registrar

Per

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/24 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Valvular Disease of Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) [signature] M. D. (Coroner.)

2/25, 1927 (Address) 502 Reliance

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet — DATE OF BURIAL: 2/27 1927

20 UNDERTAKER: Jas E Wright — ADDRESS: 564 N Carey

Cor.—12-9-25—A Co.—200 Bks.

E 19432

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19432

## CERTIFICATE OF DEATH

1-PLACE OF DEATH Glenburnie, Pronounced dead at 6:30 P.M. REGISTERED NO. 3274-001

City of BALTIMORE: (No. ____ Ward) If death occurred in Hospital or Institution, give its NAME instead of street and number and fill out No.

2-FULL NAME Wm A. Fogle

(a) RESIDENCE NO. 237 Md Ave, St. Ward Balto, Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Fogle

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | about 49 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor School

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown

(State or country)

14 Informant Timothy Mcauliffe

(Address) 257 N. Root St

Filed ____ 19 ____ C. HAMPSON JONES, M. D. Registrar

6 1927

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22 - 1927

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquest, Autopsy or Inquiry, thereon and from the evidence obtained by Autopsy and Inquest and from Autopsy and Inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) At once yrs. mos. ds.

CONTRIBUTORY (Secondary) ____ (duration) yrs. mos. ds.

(Signed) Thos. B. Horton M. D.

(Coroner)

Feb 24 1927 Address) Curtis Bay, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side of additional directions.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ____

Former or usual residence ____

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Ward's Chapel Cemetery Feb. 26 1927

20 UNDERTAKER — ADDRESS

Nelson E. Stiles 231 Md Ave Westport

Or DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9 25—A Co.—200 Bks.

E 19433

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19433

## CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

REGISTERED NO. 1573

City of BALTIMORE: (No. 328 Woodyear St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Catherine Thomas

(a) RESIDENCE NO. 328 Woodyear St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Colored | Widow |

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Charles Henry Thomas

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 65 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of Industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) Howard Co

(State or country) Md

PARENTS

10 NAME OF FATHER John Godman

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Howard Co Md

12 MAIDEN NAME OF MOTHER Sarah Williams

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Howard Co Md

14 Informant Mary C. Thomas

(Address) 328 Woodyear

15 Date 2 26 1927 C. HAMPSON JONES, M. D.

Per N.K. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 23 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan 15, 1924, to Feb 22, 1927,

that I last saw h.. alive on Feb 22, 1927,

and that death occurred, on the date stated above, at 3.30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 3 yrs. 1 mos. 7 ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. Hampson Jones, M. D.

2/23, 1927 (Address) 1928 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Mt. Auburn Cemetery | Feb 27, 1927 |
| **20 UNDERTAKER** | **ADDRESS** |
| Wm. Statie R. Williams | 322 N. Schroeder St |

If DEATH in part terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 19434

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19434

## CERTIFICATE OF DEATH.

11-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 1716 W. Franklin ST. 19-27 WARD)

2-FULL NAME Samuel J. White

(a) RESIDENCE NO. 1716 W. Franklin ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored. | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mamie White

6 DATE OF BIRTH (month, day, and year) May 1st 1895 Unknown

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| 31 32 | 9 — | 23 — | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Swift & Company

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James H. White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Annie Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mamie White (Address) 1716 W. Franklin St

15 FILED 2 6 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2 — 24 — 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 23d, 1927, to Feb 24th, 1927, that I last saw him alive on Feb 24th, 1927 and that death occurred, on the date stated above, at 6:45 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) La Grippe

(duration) yrs. mos 10 ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jas C Carper, M. D.

, 19 (Address) 1063 Myrtle Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery — DATE OF BURIAL Feb. 27, 1927

20 UNDERTAKER Mrs. Katie R. Williams — ADDRESS 322 N. Schroeder St

OCCUPATION—Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec. 7-17-26 —A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19435

## CERTIFICATE OF DEATH

91-0E 19435

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 547 St. Monroe 19-28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Emrich

(a) RESIDENCE NO. 547 St. Monroe St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 7 mos. 5 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow.

5a If married, widowed or divorced (or) WIFE of Louis Emrich.

6 DATE OF BIRTH (month, day, and year): July 20 1850

7 AGE: Years 76 Months 7 Days 5 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Joseph Braun

11 BIRTHPLACE OF FATHER (City or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known (State or country)

14 Informant Mr. Dennis A. Emrich (Address) 547 S. Monroe St

15 Filed 2 6 1927 C. HAMPSON JONES, M. D. Registrar Per [illegible]

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 25 1927

17 I HEREBY CERTIFY, That I attended deceased from June 5. 1926. to Feb 25. 1927.

that I last saw h alive on Feb 24. 1927.

and that death occurred, on the date stated above, at 4.45 P. m.

The CAUSE OF DEATH* was as follows:

For a period (duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 1½ yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Howard Kelly M. D.

2/28. 1927 (Address) 2027 Mt. Royal

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — Date of Burial: Feb. 28 1927

20 UNDERTAKER: Henry Hoeck & Son — ADDRESS: 1301 E Eager St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19436

## CERTIFICATE OF DEATH.

1827 E 19436

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital St., 9-18 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Fuld

(a) RESIDENCE NO. 1306 N. Central Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna M. Fuld

6 DATE OF BIRTH (month, day, and year) July 25/~~1873~~ 1870

| AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | ~~53~~ 56 | 0 | ~~29~~ 30 | |

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manufacturer

(b) General nature of industry, business, or establishment in which employed (or employer) Toys

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Jacob Fuld

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Abell

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Lenna.

14 Informant Mrs. Anna M. Fuld

(Address) 1306 N. Central Ave.

15 2 8 1927 C. HAMPSON JONES, M. D. Registrar

Per

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 24/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) Inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Shock-Fractured ribs & leg & intra-thoracic Hemorrhage. Accidently fell from roof of building at Harford & Lanvale Aves

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Koller M. D.

(Coroner)

2/25/27 (Address) 503 E. North Ave

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery Date of Burial Feb. 28 1927

20 UNDERTAKER Henry Ford & Son ADDRESS 1301 E Eager St

Use black ink or indelible pencil. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—506 Bks.

E 19437

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19437

## CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH St Josephs Hospital

CITY OF BALTIMORE (No. Caroline & Oliver · ST. 10-14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. McGuire.

(a) RESIDENCE NO. 934 N. Central Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. 7 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | married |

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Mary McGuire.

6 DATE OF BIRTH (month, day, and year) July 16 1869

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 57 | 7 | 10 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer Odd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Bernard McGuire

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Barrow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Mary A. McGuire.

(Address) 934 N. Central Ave

15 Filed 2 6 1927 C. HAMPSON JONES, M. D., Registrar

Per A.R.P.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 26 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan 11, 1927, to Feb 26, 1927,

that I last saw him alive on Feb. 26, 1927,

and that death occurred, on the date stated above, at 5.50 a m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

Chr. Nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Diabetic Gangrene of toe.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? Yes Date of 1/27/27

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Frank R DeSanto, M. D.

2/26/27 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL Mar 1st 1927

20 UNDERTAKER Henry Hook Sons — ADDRESS 130 E Eager

PLEASE WRITE PLAINLY. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19438

E 19438

101-001

## CERTIFICATE OF DEATH

1-PLACE OF DEATH Morris Hospital REGISTERED NO.

City of BALTIMORE: (No. 22-6 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Wibbert

(a) RESIDENCE NO. 42 E York St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 Color or Race White

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 13 - 1871

7 AGE Years 55 Months 3 Days 11 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) East Orange, N.J.

(State or country)

PARENTS

10 NAME OF FATHER Albert Wibbert

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Jane Gallagher

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Mrs Margaret Wibbert

(Address) Morristown N.J.

15 Filed 1927 16 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 24, 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 24 19 27 to Feb. 24 19 27

that I last saw him alive on Feb 24 19 27

and that death occurred, on the date stated above, at 1:20 P.M.

The CAUSE OF DEATH* was as follows:

Kidney Insufficiency

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 42 E. York St

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy & Clinical

(Signed) H W Bradley M. D.

19 27 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Morristown, N.J. Date of Burial 1/26 1927

20 UNDERTAKER Wm J. Pickrum & Sons ADDRESS Penna Road

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

6

Spec.—J-12-23—M&T—500 Bks.

E 19439

# HEALTH DEPARTMENT—CITY OF BALTIMORE

10 001 E 19439

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. JOHNS HOPKINS HOSPITAL ST. 5-8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thelma Mone

(a) RESIDENCE NO. 1309 E. Fayette ST Ally WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1926

7 AGE: Years | Months: 8 mos | Days | If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md —

PARENTS

10 NAME OF FATHER Unknown —

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Rose —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant (Address) Records — JOHNS HOPKINS HOSPITAL

15 Filed FEB 26 1927 C. HAMPSON JONES, M. D. Registrar
Per 1083 Asst

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/22 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 22, 1927 to Feb 22, 1927.
that I ~~saw~~ never saw her alive on , 19
and that death occurred, on the date stated above, at 7.45 m

The CAUSE OF DEATH* was as follows:
Laryngeal diphtheria

(duration) 0 yrs. 0 mos 4 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1309 E. Fayette St.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) H. L. Handley, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL 19

20 UNDERTAKER | ADDRESS

Commissioner of Health.

Per [illegible]

NOTE—It is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19440

## CERTIFICATE OF DEATH

E 19440

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Homewood Hosp

CITY OF BALTIMORE: (No.) 2724 (ST.) N Charles (WARD) 9-46

2-FULL NAME Mrs E Burton

(a) RESIDENCE NO. 1705 Abbottston WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. 3 ds. How long in U. S., if of foreign birth? 59 yrs. 4 mos. 13 ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fmale

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Jno R Burton

6 DATE OF BIRTH (month, day, and year): Aug 10 1867

7 AGE: Years 59 | Months 4 | Days 13 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Co Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Co Md

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Scotland

14 Informant (Address): Dr. Alex Fetherolf

15 Filed 2 0 1927, 19 C. HAMPSON JONES, M. D. Registrar

Per A.B.R.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 23 - 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 21, 1927, to Feb 23, 1927

that I last saw h alive on Feb 23, 1927

and that death occurred, on the date stated above, at 2:45 m.

The CAUSE OF DEATH* was as follows:

I (illegible) pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1705 Abbottston St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Alex Fetherolf M. D.

(Address) 2724 N Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Feb 20 1927.

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS: 106 W. NORTH AVE.

TION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 19441

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19441

## CERTIFICATE OF DEATH.

74-081

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2038 Park Avenue ST. 14-70 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane Catherine Tingle

(a) RESIDENCE NO. 2038 Park Avenue ST., WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 82 yrs. 0 mos. 22 ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of David Paul Tingle

6 DATE OF BIRTH (month, day, and year) Feb-2-1845

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 82 | 0 | 22 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Prince George Co. Maryland

PARENTS

10 NAME OF FATHER George H. Waters

11 BIRTHPLACE OF FATHER (city or town) Prince Geo. Co. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Dixon

13 BIRTHPLACE OF MOTHER (city or town) Prince Geo. Co. (State or country) Maryland

14 Informant Mrs. Oscar D. Green (sister)

(Address) 2038 Park Avenue

15 FEB 26 1927 C. HAMPSON JONES, M. D. Registrar

Per BRK

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 24th 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 24 , 19 27 , to Feb 24 , 19 27 , that I last saw her alive on Feb 24th , 19 27 , and that death occurred, on the date stated above, at 11.25 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C. H. Jones, M. D.

2/26, 19 27 (Address) 720 N. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| New Cathedral Cemetery | Feb-28-27 19 |

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE

TION is very important. See instructions on back of certificates.

HAAS

Spec.—7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19442

E 19442

## CERTIFICATE OF DEATH

103

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2705 W Fairmount Ave Ward 70-69

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilhelmina Haas

(a) RESIDENCE NO. 2705 W. Fairmount Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 2 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm C. Haas

6 DATE OF BIRTH (month, day, and year) March 25, 1856

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min.. |
|---|---|---|---|---|
| | 70 | 10 | 30 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Amelia Geiser

(Address) 2705 W. Fairmount Ave

26 1927

C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 Feb 24

17 I HEREBY CERTIFY, That I attended deceased from Feb. 20. 1927 to Feb. 24. 1927

that I last saw her alive on Feb. 24. 1927

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia.

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Cardiac dilatation & Dropsy.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Thomas S. Blake M. D.

2-27-1927 (Address) 1014 N Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery Date of Burial Feb 28 1927

20 UNDERTAKER George J. Smith ADDRESS 1532 Hollins

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19443

## CERTIFICATE OF DEATH.

100-001 E 19443

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1372 Carey St. 15-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Wilkins Jr.

(Residence in Baltimore: No. 1372 Carey St.; yrs. mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)

6-DATE OF BIRTH, ~~Sept 11~~ (Month) ~~Sept~~ (Day) ~~11~~ , 1926 (Year)

7-AGE, ~~1 yr.~~ 5 Months yrs. mos. 17 ds.

If LESS than 1 day, ....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Frank Wilkins Sr.

11-BIRTHPLACE OF FATHER (State or Country), North Carolina

12-MAIDEN NAME OF MOTHER Gladys Taylor

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Wilkins Sr.

(Address) 1372 Carey

15- FEB 26 1927 1[illegible] C. HAMPSON JONES, M. D.

per ..... Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 25 - 1927, 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 22 1927, to 2-25-1927, that I saw him alive on 2-25-1927, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Bronchis Pneumonia

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Bronchitis

(Duration) yrs. mos. 4 ds.

(Signed) C. H. Jones M. D.

, 191... (Address) 1618 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cemetery — DATE OF BURIAL, Feb. 26, 1927

20-UNDERTAKER Mrs Jas H. Dennis per T. E. Kelson — ADDRESS 1303 Presstman St.

Important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

# E 19444 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129 E 19444

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH West Balto General Hospital

CITY OF BALTIMORE: (No. Lynor and Inbeland (St.) 15-68 (WARD)

2-FULL NAME John Sparrow

(a) RESIDENCE NO. 2505 Walbrook Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Susie M Sparrow

6 DATE OF BIRTH (month, day, and year): Aug 29 1883

7 AGE: Years 44 Months 5 Days 26 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED: Retired

(a) Trade, profession or particular kind of work: Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: John K Sparrow

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Rachel Groom

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Susie M Sparrow

(Address): 765 Brookfield St

15 Filed FEB 1927, 19 ARB Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/25 19 27

17 I HEREBY CERTIFY, That I attended deceased from 2/20, 1927. to 2/25, 19 27.

that I last saw him alive on 2/25, 19 27

and that death occurred, on the date stated above, at 1.20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary): Acute uremia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Benjamin Miller, M. D.

, 19 (Address) W. B. & A. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Michaels Md — DATE OF BURIAL: 2/28 1927

20 UNDERTAKER: J. M. Cook — ADDRESS: 502 E Baltimore

TION is very important See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

E 19445

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19445

## CERTIFICATE OF DEATH

131

1-PLACE OF DEATH University Hospital REGISTERED NO.

City of BALTIMORE: (No. S. 12-19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael E. Murphy

(a) RESIDENCE NO. 405 E Lafayette Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna A Murphy

6 DATE OF BIRTH (month, day, and year) Jan 17, 1899

| 7 AGE | Years | Months | Days | IF LESS than 1 day ...hrs. or ...min.. |
|---|---|---|---|---|
| | 28 | 1 | 7 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Caisson Operator

(b) General nature of industry, business, or establishment in which employed (or employer) B & O R.R

(c) Name of employer

9 BIRTHPLACE (city or town) Balt

(State or country) Md

PARENTS

10 NAME OF FATHER John Murphy

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Balt Md

12 MAIDEN NAME OF MOTHER Anderson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balt Md

14 Informant Anna A Murphy

(Address) 405 E. Lafayette Ave

16 1927 C. HAMPSON JONES, M. D. Registrar

Per ARH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

2-24-27

17 I HEREBY CERTIFY, That I attended deceased from 2-2-27, 19..., to 2-24-27 19..., that I last saw him alive on 2-24-27 19..., and that death occurred, on the date stated above, at 12:15 P m.

The CAUSE OF DEATH* was as follows:

Peripeal abscess

Cellulitis Abdominal Wall

Cystitis

(duration) yrs. mos. 22 ds.

CONTRIBUTORY Lobar Pneumonia (Secondary)

Pneum (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Data of 1-3-27

Was there an autopsy? No

What test confirmed diagnosis? Lab. & Clinical

(Signed) Edw Teagarden, M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — Date of Burial Feb 28 19 27

20 UNDERTAKER J. E. Cook — ADDRESS 502 E Lafayette

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19446

E 19446

## CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH West Balto General Hospital

CITY OF BALTIMORE: (No. Fayette and Dukeland (ST.) 25 (WARD)

2-FULL NAME Mrs. Catherine Irwin

(a) RESIDENCE NO. 120 W. Franklin ST. Y.W.C.A. WARD Bridgeville Del.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Charles E Irwin

6 DATE OF BIRTH (month, day, and year): July 1866

7 AGE: Years 60 Months 7 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: William Coulburn

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Richmond

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mrs Lona Wagner

(Address) 2402 N Calvert St

15 Filed 2 28 1927 C. HAMPSON JONES, M. D. Registrar

Per Cox

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/25 1927

17 I HEREBY CERTIFY, That I attended deceased from 2/22, 1927, to 2/25, 1927

that I last saw her alive on 2/25 1927

and that death occurred, on the date stated above, at 6 15 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Benjamin Welker M. D.

, 19 (Address) W. B. & H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bridgeville Del

DATE OF BURIAL: 2/28 1927

20 UNDERTAKER: W. W. Cook

ADDRESS: 503 E Fayette

THIS is very important See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19447

38 E 19447

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St. 17-24 Ward)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Jackson

(a) RESIDENCE NO. 904 Little Pine St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Negro | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1894

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 33 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labour

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER William Jackson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Molley

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 [illegible] BALTIMORE CITY HOSPITALS

(Address) Records

C. HAMPSON JONES, M. D.

15 Filed [illegible] 1927 Registrar

Per 1081

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 24 1927

17

I HEREBY CERTIFY, That I attended deceased from February 15 1927, to February 24 1927, that I last saw him alive on February 24 1927, and that death occurred, on the date stated above, at 6.20 P m.

The CAUSE OF DEATH* was as follows:

Lyphulus
Myocarditis (chronic) & Gangrene Toes
Gangrene both feet

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? general & laboratory

(Signed) R. Hopper Smith, M. D.

Feb 26 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [illegible] Date of Burial 2-27-27

20 UNDERTAKER Daniel Easton ADDRESS

JOHNS HOPKINS HOSPITAL FEB 27 1927

Commissioner of Health

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPAT... is very important. See instructions on back of certificates.

2 6 1927

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19448

## CERTIFICATE OF DEATH

129

E 19448

REGISTERED NO. _____

1-PLACE OF DEATH

City of BALTIMORE: (No. 3157 Elmora ave St., 8-40 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence C Colwell

(a) RESIDENCE NO. 3157 Elmora ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. da. How long in U. S. if of foreign birth? yrs. mos. da.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm H Colwell

6 DATE OF BIRTH (month, day, and year): June 13-1866

7 AGE: Years 60 Months 8 Days 11 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: —

9 BIRTHPLACE (city or town): Baltimore.

(State or country)

PARENTS

10 NAME OF FATHER: Henry L. Clinton

11 BIRTHPLACE OF FATHER (City or town): W. Va

(State or country)

12 MAIDEN NAME OF MOTHER: Mary E Counts

13 BIRTHPLACE OF MOTHER (City or town): Baltimore.

(State or country)

14 Informant: F Gertrude Colwell

(Address) 3157 Elmora ave

15 Filed: C. HAMPSON JONES, M. D. Registrar

Per CRH

26 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 24 1927

17 I HEREBY CERTIFY, That I attended deceased from about 1 to mos. Feb 24.

that I last saw h[illegible] alive on Feb 23 1927.

and that death occurred, on the date stated above, at about 10 a. m.

The CAUSE OF DEATH* was as follows:

Nephritis

Hypertension Pulmonary edema

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted: —

If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Aut

(Signed) W. J. Riley, M. D.

Feb. 25 1927 (Address) 1639 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — Date of Burial: Feb 28 1927

20 UNDERTAKER: Robt J James & Son — ADDRESS: 1642 E Broadway

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19449 — 74-81 — E 19449

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH 555 Moore St

City of BALTIMORE: (No. Mary Carter St. 17-24 Ward)

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Mary Carter

(8) RESIDENCE NO. 555 Moore St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Richie Carter

6 DATE OF BIRTH (month, day, and year): 3/3/1859

7 AGE: Years 67 | Months 11 | Days 20 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Unknown

14 Informant Eddie Hawkins

(Address) 559 Druid Hill Ave

15 C. HAMPSON JONES, M. D.

Registrar

Per

2 6 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/23/1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 18, 1927, to Feb. 26, 1927, that I last saw h[illegible] alive on Feb. 22, 1927 and that death occurred, on the date stated above, at 2:45 a m.

The CAUSE OF DEATH* was as follows:

Paralysis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage (duration) yrs. mos. 4 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was There an autopsy? No

What test confirmed diagnosis? Clinical

Signed John H. Shipman M. D.

2/23/27 (Address) 1219 Druid Hill ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery — Date of Burial Feb. 26 1927

20 UNDERTAKER Jno. M. Johnson — ADDRESS 1234 Eutaw St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUP[illegible]ON is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

# E 19450

## HEALTH DEPARTMENT—CITY OF BALTIMORE

74 E 19450

### CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5210 Ferndale Ave., ST. 28th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Timothy Joseph O'Neill.

(a) RESIDENCE NO. 5210 Ferndale Ave., ST., ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married. |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha O'Neill.

6 DATE OF BIRTH (month, day, and year) Sept. 17, 1854

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 72 | 5 | 7 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington, D. C.

PARENTS

10 NAME OF FATHER Joseph O'Neill.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Carroll,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Bertha O'Neill (Address) 5210 Ferndale Ave.

15 2 6 1927 C. HAMPSON JONES, M. D. Registrar Per .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 24 1927

17 I HEREBY CERTIFY, That I attended deceased from Feby 13, 1927, to Feby 24, 1927, that I last saw him alive on Feby 23, 1927, and that death occurred, on the date stated above, at 6.08 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Apoplexy)

(duration) ..... yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

2/26, 1927 (Signed) W. O'Neill M. D.

(Address) 108 N Bethune

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem. DATE OF BURIAL 2/28 1927

20 UNDERTAKER Harry Hartzler 1031 W Lanvale ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 19451

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19451

## CERTIFICATE OF DEATH.

74-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1639 N. Monroe ST. 15 H WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Wilhelmina Grandy

(a) RESIDENCE No. 1639 N Monroe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Joseph Grandy.

6 DATE OF BIRTH (month, day, and year): Dec 31 - 1862

7 AGE — Years: 64 | Months: 1 | Days: 25 | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER: Jacob Bopp.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Joseph Grandy (Address) 1639 N. Monroe St.

15 2 6 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feby 25 1927

17 I HEREBY CERTIFY, That I attended deceased from Feby 25 11 A.M. 1927, to Feby 25 4 P.M. 1927, that I last saw her alive on Feby 25 1927, and that death occurred, on the date stated above, at 4 20 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

Died Instantly (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis with Hypertension and (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Chronic Endocarditis

Did an operation precede death? Date of

Was there an autopsy? Duration two or

What test confirmed diagnosis? more years

(Signed) O. H. Duvall M. D.

, 19 (Address) 137 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: 2/28 1927

20 UNDERTAKER: Harry A. Seltzer

ADDRESS: 1031 W. Lombard

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

~~19459~~ ✓

157 E 19452

E 19452

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Home for Incurables

CITY OF BALTIMORE: (No. Cedar Ave & Hollins St., 13-52 WARD)

2-FULL NAME Mrs Ella Virginia Hobbitzell

(a) RESIDENCE NO. Home for Incurables ST., ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of S A Hobbitzell

6 DATE OF BIRTH (month, day, and year) 9-9-1843

| 7 AGE Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|
| 83 yrs | 5 Mos | 17 | |

8 OCCUPATION OF DEACEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER James Follin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Cross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Solomon Hobbitzell

(Address) Belair Md

15 Filed ....., 19..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 26 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1927 to Feby 26, 1927

that I last saw her alive on Feby 26, 1927

and that death occurred, on the date stated above, at 7 30 p. m.

The CAUSE OF DEATH* was as follows:

Septicaemia

(duration) — yrs. — mos 3 ds.

CONTRIBUTORY (Secondary) Chronic Ulcerative Colitis (duration) over 5 yrs. — mos. — ds.

18 Where was disease contracted Same as 1st above

If not at place of death? .....

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical exam

(Signed) W W Mayo, M. D.

2/26, 1927 (Address) Baltimore Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Mt Zion, Belair | Feby 28, 1927 |

20 UNDERTAKER Dean & Foster ADDRESS Belair, Md

FEB 27 1927 THOMPSON JONES, M. D.

TION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF OCCUPA-

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 19453

REGISTERED NO. ~~E 19455~~ E 19453

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. 4-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriet E Veasey

(a) RESIDENCE NO. Have De Grace St. Md Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| F | W | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Feb. 2, 1909

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 18 | 0 | 24 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Duties

(b) General nature of industry, business, or establishment in which employed (or employer) Lewis, Del.

(c) Name of employer

9 BIRTHPLACE (city or town) Lewis, Del.

(State or country)

PARENTS

10 NAME OF FATHER W.E. Veasey

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Del.

12 MAIDEN NAME OF MOTHER Essie M Bonnefield

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant W.E. Veasey

(Address) Havre de Grace Md.

15 Filed FEB 27 1927 19 HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 24, 1926, to Feb 26, 1927.

that I last saw h alive on Feb 26, 1927

and that death occurred, on the date stated above, at 7 30 P.m.

The CAUSE OF DEATH* was as follows:

Pneumococci Meningitis (5 days)

Otitis Media 30 days,

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? None.

(Signed) E. R. Miller M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Havre de Grace, Md. Date of Burial [illegible] 27

20 UNDERTAKER R. Madison Mitchell ADDRESS Havre de Grace Md.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

Roland ave & University Pkwy.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 19454
1-PLACE OF DEATH

REGISTERED NO. E 19454
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) The Chadford Apts ST. 27-5 1/2 29 WARD)

2-FULL NAME Joseph R. Wilson

(a) RESIDENCE NO. The Chadford Apts ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | white | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kate Wilson

6 DATE OF BIRTH (month, day, and year) July 20 1867

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs. or ....min. |
|---|---|---|---|---|
| | 59 | 7 | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bonding Co's

(b) General nature of industry, business, or establishment in which employed (or employer) Md Casualty Co

(c) Name of employer

9 BIRTHPLACE (city or town) Augusta Ga.
(State or country)

PARENTS

10 NAME OF FATHER Jos. R. Wilson

11 BIRTHPLACE OF FATHER (city or town) Steubenville Ohio
(State or country)

12 MAIDEN NAME OF MOTHER Jessie Woodrow

13 BIRTHPLACE OF MOTHER (city or town) Glascow Scotland
(State or country)

14 Informant Alice Wilson McElroy
(Address) 4507 Park ave Nashville Tenn

Filed FEB 27 1927 HAMPSON JONES, M. D.
Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26th 1927

17 I HEREBY CERTIFY, That I attended deceased from July 1st, 1926, to Feb 26th, 1927.

that I last saw him alive on Feb 26th, 1927.

and that death occurred, on the date stated above, at 12.15 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 7 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) — yrs. — mos. 5 — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Ira E Whitehill, M. D.

2/26 1927 (Address) 230 E Lenox Blvd Forest Park Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Clarksville Tenn

DATE OF BURIAL Feb 27 1927

20 UNDERTAKER Henry H Jenkins Sons

ADDRESS McCulloh & Oakland

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19455

## CERTIFICATE OF DEATH.

90 E 19455
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1255 E. Tyson St. 5-8 WARD)

2-FULL NAME Martha Wilson

(a) RESIDENCE NO. 1255 E. Tyson ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Colored | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas. Wilson

6 DATE OF BIRTH (month, day, and year) 3-12-1855

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| 71 | 72 | 11 | 12 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Jas Hardy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Bessie Wilson
(Address) 1255 E. Tyson St

15 Filed ....., 19..... Per ..... Registrar

C. HAMPSON JONES, M. D.

B 27 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 24 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 16, 1927, to Feb 23, 1927.

that I last saw her alive on Feb. 23, 1927

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular heart disease

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robert J. Green M. D.

2-24, 1927 (Address) 120 Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL Feb. 27 27

20 UNDERTAKER Wm J. G. Locks — ADDRESS 1302 ff

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19456

## CERTIFICATE OF DEATH.

101 001 E 19456

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1119 Woodyear St. 16-23 WARD)

2-FULL NAME Mrs. Rosa Anna Bene

(a) RESIDENCE NO. 1110 Woodyear ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colord

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George W. Bene

6 DATE OF BIRTH (month, day, and year): June 30-1879

7 AGE: Years 47 Months 7 Days 24 — If LESS than 1 day, ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer): ——— OHI

(c) Name of employer: ———

9 BIRTHPLACE (city or town) (State or country): Accomac Co. Va

PARENTS

10 NAME OF FATHER: Ezer Poulson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Julia Gaines

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant (Address): Mr. Geo. W. Bene 1110 Woodyear

Filed FEB 27 1927 C. HAMPSON JONES, M. D. Registrar

For RK

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 24th 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 20th, 1927, to Feb. 24th, 1927.

that I last saw her alive on Feb 24th, 1927

and that death occurred, on the date stated above, at 5:45 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 1/2 ds.

CONTRIBUTORY (Secondary): Cerebral Hemorrhage (duration) 2 hrs. yrs. mos. ds.

18 Where was disease contracted if not at place of death? ———

Did an operation precede death? No Date of ———

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) A. E. Bell M. D.

, 19 (Address) 713 Gilmor

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL Feb. 28 1927

20 UNDERTAKER: Eugene Burke — ADDRESS 1430 Gay

Spec.—1-10-21—M&T 1500 Bks.

E 19457

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

185 E 19457

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1603 Pennington Ave 25-25 WARD)

2-FULL NAME Samuel F. Parker

(a) RESIDENCE No. 1603 Pennington Ave St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | White | Married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Blanche H. Parker

6 DATE OF BIRTH (month, day, and year) Mar 1, 1857.

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs or ....min. |
|---|---|---|---|---|
| | 69 | 2 | 25 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) VA.

PARENTS

10 NAME OF FATHER Franklin Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country) VA

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) VA

14 Informant Mrs. Fred. S. Collison

(Address) 1607 Pennington Ave (Daughter)

15 Filed 3 27 1927 19 C. Hampson Jones, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 26, 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 3, 1926 to Feb 26, 1927.

that I last saw h/m alive on Feb 25, 1927,

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation

Fracture of Left. Femur

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilitation Immeadiate.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No -

What test confirmed diagnosis? Signs & Symptoms.

(Signed) James E. Peterman M. D.

, 19 (Address) 1229 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Milford Va.

DATE OF BURIAL Feb 28 1927

20 UNDERTAKER Frank A. Ferrando

ADDRESS 703 N

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Jennie E. Snyder. ✓

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 19458 — 90 E 19458

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 711 E. Fort Ave. ST. 24 34 WARD)

2-FULL NAME Jennie E. Snyder

(a) RESIDENCE NO. 711 E. Fort Ave. ST., ..... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John L. Snyder

6 DATE OF BIRTH (month, day, and year): Nov. 15th 1851

7 AGE: Years 75 Months 3 Days 8 If LESS than 1 day, hrs. or ..... min. 9.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Henry Young

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Eliza Worley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: John L. Snyder

(Address): 711 E. Fort ave

15 Filed FEB 27 1927 C. HAMPSON JONES, M. D. Registrar

Per RK

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 24th 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 15th, 1926, to Feb. 24th 1927. that I last saw her alive on Feb 24th 1927. and that death occurred, on the date stated above, at 11 35 P. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis and chronic aortic regurgitation.

(duration) — yrs. 3 mos 19 ds.

CONTRIBUTORY (Secondary) Acute dilatation of heart

(duration) Chronic yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical examination

(Signed) D. Parker Heibel M. D.

2/26, 1927 (Address) 1224-26 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Brownsville, Md.

DATE OF BURIAL: 2/27 1927

20 UNDERTAKER: C. D. Flannery, Inc. 1460

ADDRESS: Battery Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

188-003

E 19459

## CERTIFICATE OF DEATH.

E 19459

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE (No. Dr. Kelly's Hospital S. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Waters

(a) RESIDENCE NO. 1506 Madison Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 23- 1922

7 AGE — Years: 4 — Months: 3 mo — Days: 1 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER: Frank Waters

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER: Elizabeth Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant: Frank Waters (Address) 1506 Madison Ave.

15 Filed FEB 27 1927 19 C. HAMILTON JONES, M. D. Registrar

Per

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 24 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of pelvis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) automobile accident

(duration) yrs. mos. ds.

(Signed) J. J. Hennessy M. D.

(Coroner)

Feb 26, 1927 (Address) 702 E Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — Date of Burial Feb 27 1927

20 UNDERTAKER: Samuel Kemsley — ADDRESS 1178 N Bradford

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19460

1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

90

E 19460

REGISTERED NO.

City of BALTIMORE: (No. Sinai Hospital of Balto St. 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva Berger

(a) RESIDENCE NO. 1139 E. Lombard St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? 23 yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Moris Berger

6 DATE OF BIRTH (month, day and year): Unknown

7 AGE: Years 67 | Months — | Days — | IF LESS than 1 day .... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Russia

14 Informant Moris Berger

(Address) 1139 E. Lombard St

Filed FEB 27 1927

C. HAMPSON JONES, M. D.

Registrar

For RR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Feb. 27. 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb. 18, 1927 to Feb 27, 1927, that I last saw h.e.s. alive on Feb 27, 1927, and that death occurred, on the date stated above, at 11:45 a. m.

The CAUSE OF DEATH* was as follows:

Hypertension

Arteriosclerosis

Myocarditis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardio-vascular failure

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) William Schuman, M. D.

2/27, 1927 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rehreen Southern Ave

Date of Burial: 2/27 1927

20 UNDERTAKER: Jack Lewis

ADDRESS: 1429 E Balt St

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19461

## CERTIFICATE OF DEATH.

101-001

E 19461

1-PLACE OF DEATH West Baltimore General Hospital REGISTERED NO.

CITY OF BALTIMORE: (No Reyna and Dukeland ST.) 15-6B WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Milton Hyman

(a) RESIDENCE NO. 2017 Ruxton Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie Hyman

6 DATE OF BIRTH (month, day, and year) Nov 22-1897

7 AGE — Years: 29 | Months: 3 | Days: 5 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Collector

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore City Md

PARENTS

10 NAME OF FATHER Isaac Hyman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER Bessie Goldstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant Isaac Hyman

(Address) 1721 Ft Ave Baltimore

FEB 27 1927

15 Filed H. HAMPTON JONES, M. D. Registrar

per R.R.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/27/27 19

17 I HEREBY CERTIFY, That I attended deceased from 2/24, 1927 to 2/27, 1927 that I last saw him/her alive on 2/27, 1927 and that death occurred, on the date stated above, at 4 30 A. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Benjamin Miller, M. D.

2-27, 19 (Address) W. B. & A. R.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Hessian Rum — DATE OF BURIAL: 2/27 1927

20 UNDERTAKER: Jack Lewis — ADDRESS: 1439 E Baltimore St

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 19462

90 E 19462

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1204 St. Matthews St St. 58 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Isaac Norvick

(a) RESIDENCE NO. 1204 St. Matthew St. Ward

(Usual) place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Norvick

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 67 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER Laib Norvick

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Rachel

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Bessie Norvick

(Address) 1204 St. Matthew St.

15 Filed ..... 19 .....

Per ..... Registrar

C. HAMPSON JONES, M. D.

FEB 27 1927

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27/27 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Probably Chr. Myocarditis

(duration) ....yrs. ....mos. ....ds.

(Signed) J. W. Pacca M. D.

(Coroner)

2/27/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale Date of Burial 3/2 19 27

20 UNDERTAKER Jack Davis ADDRESS 1439 E Balto St

Use ditto marks for carefully supplied. Acts should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19463 E 19463

## CERTIFICATE OF DEATH

1-PLACE OF DEATH Hebrew Home for Incurables 129

CITY OF BALTIMORE (No. 2100 E. Balto. St. 12-65 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruben Rozenberg

(a) RESIDENCE No. 3210 Vickers Road ST. WARD
(Usual place of abode)
Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.
(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | white | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bailey Rosa Rozenberg

6 DATE OF BIRTH (month, day, and year) [illegible]

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 90 | | | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Samuel J. Rozenberg
(Address) 3210 Vickers Road

FEB 27 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-26- 19 27

17 I HEREBY CERTIFY, That I attended deceased from Jan 26, 19 26, to Feb 26, 19 27.
that I last saw h[illegible] alive on Feb 26, 19 27
and that death occurred, on the date stated above, at 6:30 P. m.
The CAUSE OF DEATH* was as follows:

a Nephritis

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) [illegible], M. D.
, 19 (Address) 810 Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem
UNDERTAKER Jack Lewis 1439 E. Lan[illegible]

DATE OF BURIAL 2/27 1927
ADDRESS

CAUSE OF DEATH to be given in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 19464

REGISTERED NO. E 19464

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. 46 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Morris

(a) RESIDENCE NO. 612 E. Lombard st. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1877

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 50 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER John Morris

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Nora Mangler

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant Hospital Records

(Address)

Filed FEB 27 1927 HAMPSON JONES, M. D. Registrar

Per E.K.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 February 22, 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan. 11 19 26, to February 22, 19 27, that I last saw him alive on February 22, 19 27, and that death occurred, on the date stated above, at 8.45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Clinical findings

(Signed) [illegible], M. D.

2-28-27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Date of Burial 2/27 1927

20 UNDERTAKER J J Fahey Sons ADDRESS 134 Light St

This should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19465

## CERTIFICATE OF DEATH.

129 E 19465

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 614 W. North ave St: 13-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marion J. Adams

(Residence in Baltimore: No. 614 W. North Ave St.: Lifetime yrs. mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~MARRIED, WIDOWED, OR DIVORCED~~, (Write the word.) Married

6-DATE OF BIRTH, 6 (Month) – 10 (Day) – 1868 (Year)

7-AGE, 61 yrs. 8 mos. 16 ds. If LESS than 1 day, ....hrs. or ....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Thomas Hunter

11-BIRTHPLACE OF FATHER (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Adams

(Address) 801 N. Capitol St. N.W. Wash. D.C.

15-

FEB 27 1927 C. HAMPSON JONES, M. D.

Filed ..... Per ..... Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 2 (Month) 26 (Day), 1927 (Year)

17-I HEREBY CERTIFY, That I attended deceased from Feb 25, 1927, to Feb 26 1927, that I saw h[er] alive on Feb 26 1927, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Emerson R. Palmer M. D.

2/26, 1927 (Address) 3005 W North ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Woodlawn Cemetery DATE OF BURIAL, Feb 28 1927

20-UNDERTAKER Chas. F. Sause & Son ADDRESS 718 W. Mt. Royal ave

Please write in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

E 19466

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

101-001

E 19466

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 511 Willowdale Ave Ward) 27-48

2-FULL NAME Alberta J. Ruth

(a) RESIDENCE NO. 511 Willow Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. 10 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | white | widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John A Ruth

6 DATE OF BIRTH (month, day, and year) April 11 1853

| 7 AGE | Years | Months | Days 15 | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 73 | 10 | 16 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Thomas D. Roberts

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Sheldon

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) unknown

14 Informant Josephine B. Dougherty

(Address) 511 Willow ave Govans

15 Filed FEB 27 1927 C. HAMPSON JONES, M. D. Registrar

Per H.H.C.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26/1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 1927 to Feb 26 1927, that I last saw h~~er~~ alive on Feb 25 1927, and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H Wheaton, M. D.

. 19 (Address) 4309 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery Date of Burial Feby 28 1927

20 UNDERTAKER William C. Black ADDRESS 927 N. Broadway

FOR HEALTH DEPARTMENT USE ONLY

Use blank be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

109-002 E 19467

E 19467

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St. 23-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kenneth Hersch

(a) RESIDENCE NO. 104 Buckhead St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 9 mos. 19 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | Single. |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 7-1921

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min.. |
|---|---|---|---|---|
| | 5 | 9. | 19 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. ~~Child~~

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER George Hersch

11 BIRTHPLACE OF FATHER (City or town)

(State or country) not given

12 MAIDEN NAME OF MOTHER Mc. Tierney

13 BIRTHPLACE OF MOTHER (city or town) Ireland

(State or country)

14 Informant George Hersch

(Address) 104 Buckhead St

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

FEB 27 1927 Per .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-26 1927

17 I HEREBY CERTIFY, That I attended deceased from 2-25 1927 to 2-26 1927

that I last saw him alive on 2-26 1927

and that death occurred, on the date stated above, at 3.30 p m.

The CAUSE OF DEATH* was as follows:

ENDOCARDITIS

(duration) yrs. mos. 15 days

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) W. S. McBride M. D.

19 (Address) Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. Date of Burial 3/1 19 27

20 UNDERTAKER D. J. F. McAnulty ADDRESS 130 E. Fro

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 19468

90

REGISTERED NO. E 19468

1-PLACE OF DEATH

City of BALTIMORE: (No. 2719 Orleans St. St. 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Rausch

(a) RESIDENCE NO. 2719 Orleans St. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S. if of foreign birth? 44 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary M. Rausch.

6 DATE OF BIRTH (month, day, and year): June 17-1850

7 AGE — Years: 76 — Months: 8 — Days: 8 — IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailor

(b) General nature of industry, business, or establishment in which employed (or employer): 80

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Germany.

PARENTS

10 NAME OF FATHER: Andrew Rausch.

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Germany.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany.

14 Informant: Mary M. Rausch. (Wife)

(Address): 2719 Orleans St.

FEB 27 1927

Filed ..... HAMPTON JONES, M. D. Registrar

Per .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 25-1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 20, 1927, to Feb. 25, 1927,

that I last saw him alive on Feb. 25, 1927,

and that death occurred, on the data stated above, at 6.35 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis (Chronic)

..... (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial Asthma (Non Tuberculous)

..... (duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. L. Pessano, M. D.

2.26.1927 (Address) 514 Drury Lane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem. — Date of Burial: March 1 1927

20 UNDERTAKER: Lilly & Feile — ADDRESS: 403 S. Wolfe St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26–A Co.–200 Bks.

E 19469

# HEALTH DEPARTMENT—CITY OF BALTIMORE

77 E 19469

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. _____

City of BALTIMORE: (No. 1701 S. Clinton St. 26-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Selig.

(a) RESIDENCE NO. 1701 S. Clinton St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 26 1871

| 7 AGE | Years | Months | Days | IF LESS than 1 day ____ hrs. or ____ min.. |
|---|---|---|---|---|
| | 55. | 5 | 28 29 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home.

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER John Selig

11 BIRTHPLACE OF FATHER (City or town) _____

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Anna M. Lind

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Germany.

14 Informant John Selig.

(Address) 1701 S. Clinton St.

15 Filed FEB 27 1927 19 C. HAMPSON JONES, M. D. Registrar

Per _____

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 24 - 1927 19

17 I HEREBY CERTIFY, That I attended deceased from 1/12/26, 19____, to 2/24/27, 19____,

that I last saw her alive on 2/22/27, 19____.

and that death occurred, on the date stated above, at 7.30 A. m.

The CAUSE OF DEATH* was as follows:

Involutional Melancholia

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 7 ds.

18 Where was disease contracted —

if not at place of death? _____

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? _____

(Signed) W. H. Garrell M. D.

2/26 19 27 (Address) 633-S-St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Holy Redeemer Cem. | Feb. 28th 1927 |
| **20 UNDERTAKER** | **ADDRESS** |
| Lilly & Zeibe | 403 S. Wolfe St |

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19470

## CERTIFICATE OF DEATH.

83 E 19470

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 309 Loneys Lane ST. 76-11 WARD)

2-FULL NAME John F. Deinlein

(a) RESIDENCE NO. 309 Loneys Lane ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? 54 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced (or) WIFE of Margaret Deinlein

6 DATE OF BIRTH (month, day, and year) Dec. 5 - 1854

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 72 | 2 | 20 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 040

(b) General nature of industry, business, or establishment in which employed (or employer) James Lumber Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Joseph Deinlein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Margaret Deinlein

(Address) 309 Loneys Lane

15 Filed FEB 27 1927 19 Per [illegible] Registrar

C. HAMPSON JONES, M. D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 25 - 1927

17

I HEREBY CERTIFY, That I attended deceased from Nov 14, 1926, to Feb 25, 1927.

that I last saw him alive on 11 24, 1927,

and that death occurred, on the date stated above, at 4. m.

The CAUSE OF DEATH* was as follows:

Softening of Brain High Blood Pressure & Hardening of Arteries

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) above

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) A. C. Bocaccio M. D.

2/26 1927 (Address) 3907 Farrecourt Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Sacred Heart Cem. | March 1st 1927 |
| UNDERTAKER | ADDRESS |
| Lilly & Zeile | 403 S. Wolfe St |

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

154-002

## CERTIFICATE OF DEATH.

E 19471

E 19471

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 2110 W. Mulberry St., 20-69 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nancy Dewitt Denton

(a) RESIDENCE NO. 2110 W Mulberry St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | white | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 21 - 1925.

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 1 | 5 | 4 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town)

(State or country) Peyton W Va

PARENTS

10 NAME OF FATHER Lyons B. Denton

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va.

12 MAIDEN NAME OF MOTHER Mary E. Lewis

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Peyton W Va

14 Informant Mr Lyons B Denton.

(Address) 2110 W Mulberry St-

15 Filed FEB 27 1927 C. HAMPSON JONES, M. D. Registrar

By —

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25 1927

17

I HEREBY CERTIFY, That I attended deceased from Dec, 1926, to Feb 25, 1927,

that I last saw her alive on Feb 25, 1927,

and that death occurred, on the date stated above, at 8 20 P m.

The CAUSE OF DEATH* was as follows:

Congestive Heart Disease

Life (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio-pneumonia

2 (duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John Burnish, M. D.

Feb 26 1927 (Address) 11 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Clare Cem. Date of Burial 2/28/1927

20 UNDERTAKER P. J. Keegan & Son

ADDRESS 901 Hollins St

Undertaker's Certificate

I HEREBY CERTIFY, That I have embalmed the body of the above named deceased, that I have carefully inquired into and have truly stated all the particulars which have come to my knowledge concerning the death of said deceased, and that the said deceased died of the disease and at the time stated above.

Filed Feb 27 1927 By —

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19472

## CERTIFICATE OF DEATH.

129

E 19472

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1924 Lennox St. 20-28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Hemmings

(a) RESIDENCE NO. 1924 Lennox St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 9 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: white.

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Hemmings.

6 DATE OF BIRTH (month, day and year): May 7th 1857

7 AGE — Years: 69 — Months: 9 — Days: 19 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town): Maryland

(State or country): Baltimore.

PARENTS

10 NAME OF FATHER: John Woods

11 BIRTHPLACE OF FATHER (city or town): Germany

(State or country)

12 MAIDEN NAME OF MOTHER: Lukstown.

13 BIRTHPLACE OF MOTHER (city or town):

(State or country)

14 Informant: Mr August Metzger

(Address) 1924 Lennox St

15 Filed FEB 27 1927 19 C. HAMPSON JONES, M. D. Registrar

by R.H.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): February 26th 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 1927, to February 26 1927, that I last saw h.r alive on February 26 1927, and that death occurred, on the date stated above, at 7.15 A m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis.

Mitral Insufficiency. Chr

Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) M. D.

2/26, 1927 (Address) 2151 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem. — Date of Burial: 3/1 1927

20 UNDERTAKER: Geo. F. Cowan & Son — ADDRESS: 90 Holliday St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 19473 Jess. HEALTH DEPARTMENT—CITY OF BALTIMORE E 19473

CERTIFICATE OF DEATH.

1-PLACE OF DEATH U. S. Marine Hospital No. 1 23-34 REGISTERED NO. 74

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Jens.

(a) RESIDENCE No. 1502 E. Marshall st ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male. | White | Married. |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mrs Ira Jens.

6 DATE OF BIRTH (month, day, and year) 11-7-1869.

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 57 | 3 | 19. | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) Str. Power 1886

(c) Name of employer % Anthony Fenner

9 BIRTHPLACE (city or town) (State or country) NY.

PARENTS

10 NAME OF FATHER Charles Jens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Self
(Address) C. HAMPSON JONES, M. D.

Filed FEB 27 1927, 19... Registrar R.H.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 26 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 17, 1927, to Feb. 26, 1927.

that I last saw him alive on Feb 26, 1927.

and that death occurred, on the date stated above, at 4 10 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(duration) yrs. 1 mos 28 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. — mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical findings, laboratory tests

(Signed) W W Benton Asst Surgeon U.S. PHS, M. D.

2-26, 1927 (Address) U.S. Marine Hospital #1

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem. DATE OF BURIAL March 1927

20 UNDERTAKER A. Howard Evans ADDRESS 38 E Ford Ave

CAUSE OF DEATH must be stated plainly, and must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19474

166 E 19474

## CERTIFICATE OF DEATH.

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 8-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Madaline Fell

(a) RESIDENCE NO. 2401 Llewelyn St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | white | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Fell

6 DATE OF BIRTH (month, day, and year) June 27/1903

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 23 | 7 | 28 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of Industry, business, or establishment in which employed (or employer) D37

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Norvel Stevens

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) W. Va.

12 MAIDEN NAME OF MOTHER Jillian Everson

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) W. Va

14 Informant Edward Fell

(Address) 501 N. Carrollton Ave

C. HARRISON JONES, M. D

15 Filed FEB 27 1927 19____ Per _____ Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhagic Nephritis etc.
Bichloride Mercury Poisoning Feb 13
Suicide (Autopsy at Hopkins)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. Wade M. D.
(Coroner)

18 (Address) 2/26/27 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Date of Burial Feb 25 1927

20 UNDERTAKER J. W. Cook ADDRESS 502 E. Lexington St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19475

## CERTIFICATE OF DEATH

100-001

E 19475

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1733 E Pratt St St. 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward J Lisek

(a) RESIDENCE NO. 1733 E Pratt St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 23 1926

7 AGE: Years Months Days: 9 ✓ IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Albert Lisek

11 BIRTHPLACE OF FATHER (City or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Bertha Smolinska

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Bertha Lisek

(Address): 1733 E Pratt St

15 Filed FEB 27 1927 C. HAMPSON JONES, M. D. Registrar

Per RR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: Feb 25 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 24, 1926, to Feb 25, 1926, that I last saw h[illegible] alive on Feb 25-2, 1927, and that death occurred, on the date stated above, at 11.40 P m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P. S. & S.

(Signed) John L. Segerchi, M. D.

. 19 (Address) 1738 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Date of Burial: Feb 28 1927

20 UNDERTAKER: John McWeber ADDRESS: 1803 Bank St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

159,003

E 19476 — 1-PLACE OF DEATH

E 19476 — REGISTERED NO.

13

City of BALTIMORE: (No. 635 S Montford Ave St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maryanna Romecki

(a) RESIDENCE NO. 635 S Montford Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 11 1927

7 AGE — Years — Months — Days: 15 — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): balto Md

PARENTS

10 NAME OF FATHER: Wawezyn Romecki

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Poland

12 MAIDEN NAME OF MOTHER: Agnes Zakrzewski

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Poland

14 Informant: Anges Romecki

(Address): 635 S Montford Ave.

15 Filed FEB 27 1927 19 C. HAMPSON JONES, M. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 2

Feb 26 1927

17 I HEREBY CERTIFY, That I attended deceased from 2/11/27, 19 2, to 2/26, 19 2,

that I last saw h[illegible] alive on [illegible], 19 2,

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Dural Embolism (Congenital)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) [illegible]

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Autopsy

(Signed) [illegible] M. D.

19 2, (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — Date of Burial: Feb 28 19 27

20 UNDERTAKER: Joseph R Weber — ADDRESS: 1803 Bank St

IMPORTANT.—THIS CERTIFICATE, WITH CAREFUL ANSWERS TO ALL QUESTIONS, IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 19477

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

## CERTIFICATE OF DEATH.

E 19477

REGISTERED NO.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St. 18-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John P. Meehan

(a) RESIDENCE NO. 38 S. Washington Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary B. Meehan

6 DATE OF BIRTH (month, day, and year) 1891

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 36 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer) 66

(c) Name of employer

9 BIRTHPLACE (city or town) ?

(State or country) Maryland

PARENTS

10 NAME OF FATHER Edward Meehan

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen O'Donnell

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant BALTIMORE CITY HOSPITALS

(Address) [redacted] Records

15 Filed FEB 27 1927, 19

E. HAMPSON JONES, M. D.

Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 25 1927

17

I HEREBY CERTIFY, That I attended deceased from February 4 1927, to February 25, 1927,

that I last saw him alive on February 25, 1927,

and that death occurred, on the date stated above, at 5-10 P m.

The CAUSE OF DEATH* was as follows:

Inanition

Acute Pharyngitis

Acute Sinusitis

(duration) .....yrs. .....mos. 15 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) .....yrs. .....mos. 6 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? general & laboratory

(Signed) R. Hooper Lentz M. D.

Feb 26 1927 Address BALTIMORE CITY HOSPITALS [redacted]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — Date of Burial Mar 1 1927

20 UNDERTAKER Bernard A. Funk. — ADDRESS 734 Poplar Grove St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19478

100-001

## CERTIFICATE OF DEATH

REGISTERED No. E 19478

1-PLACE OF DEATH: Marlborough Apts. 5 C.

City of BALTIMORE: (No. Eutaw Place & Wilson St. 1420 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME: Fannie Blumenthal

(a) RESIDENCE NO. Marlborough Apts. 5 C. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 20th. 1861.

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 65 | 8 | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.

(State or country)

PARENTS

10 NAME OF FATHER Bernard Blumenthal

11 BIRTHPLACE OF FATHER (City or town) Germany.

(State or country)

12 MAIDEN NAME OF MOTHER Jeannetta Stern.

13 BIRTHPLACE OF MOTHER (city or town) Germany.

(State or country)

14 Informant Mr. Blumenthal

(Address) Marlborough Apts.

15 Filed FEB 27 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby. 26, 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 19th, 1927, to Feb 26, 1927, that I last saw h alive on Feb 25, 1927, and that death occurred, on the date stated above, at 3:- A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 6 da.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 2 da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Kenneth A. Asbrand, M. D.

Feb 26, 1927 (Address) 2360 Eutaw Place

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Oheb Shalom Cem. | 2/28/27 |

20 UNDERTAKER David Londrum ADDRESS 118-20 W. Mt. Royal Ave

NAME PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

E 19479

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

100-001 / 19479

E 19479

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1923 W Lexington St. 20-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Percy B. Cushen

(a) RESIDENCE NO. 1923 W Lexington St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. — mos. — ds. How long in U. S. If of foreign birth? 23 yrs. — mos. — ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ida B. Cushen

6 DATE OF BIRTH (month, day, and year): July 27 1864

7 AGE: Years 62 Months 6 Days 30

IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk 009

(b) General natura of industry, business, or establishment in which employed (or employer): Clothiers

(c) Name of employer: Greif & Co

9 BIRTHPLACE (city or town) (State or country): England

PARENTS

10 NAME OF FATHER: George B. Cushen

11 BIRTHPLACE OF FATHER (City or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Matilda Goodrich

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: Mrs. Ida B. Cushen

(Address) 1923 W Lexington St

15 Filed FEB 27 1927 By ...

C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 26 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 24, 1927, to Feb 26, 1927, that I last saw him alive on Feb. 26, 1927, and that death occurred, on the data stated above, at 2a. m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Data of

Was there an autopsy? no

What test confirmed diagnosis? Physical exam.

(Signed) H. F. Kranz, M. D.

2/26 1927 (Address) 1822 W Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reversa sida for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western

Date of Burial FEB 28 1927 19

20 UNDERTAKER: Geo W Little

ADDRESS 2708 [illegible]

FEB 27 1927

• IMPORTANT.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-00/9480

**E 19480**

1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

**E 19480**

REGISTERED NO.

City of BALTIMORE: (No. 2717 Tivoly Ave 9-46 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Dunn

(a) RESIDENCE NO. 2717 Tivoly Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 6 mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? 60 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Widowed |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Janet Dunn

6 DATE OF BIRTH (month, day, and year) Sept 19. 1841

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 85 | 5 | 7 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mining Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Retired 030

9 BIRTHPLACE (city or town)

(State or country) Scotland

PARENTS

10 NAME OF FATHER James Dunn

11 BIRTHPLACE (city or town)

(State or country) ~~Scotland~~ Ann Ferguson

12 MAIDEN NAME OF MOTHER Ann Ferguson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Scotland

14 Informant Ann F. Dunn

(Address) 2717 Tivoly Ave

Filed FEB 27 1927 C. HAMPSON JONES, M. D.

by R.H. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Feb 26, 27

17

I HEREBY CERTIFY, That I attended deceased from Feb 19, 1927, to Feb 26, 1927, that I last saw h[illegible] alive on Feb 26, 1927 and that death occurred, on the date stated above, at 10,15 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

Lobar

(duration) .....yrs. .....mos. 6 ds.

CONTRIBUTORY

(Secondary)

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? ~~Yes~~ Date of

Was there an autopsy? ~~Yes~~

What test confirmed diagnosis?

(Signed) Leo A Zimmerman M.D.

19 (Address) Feb 26 1927 1085 S Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Date of Burial

Loudoun Park Feb 28 1927

20 UNDERTAKER Mr. & Mrs. John H. Lupfer ADDRESS 801 W. Fayette

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

B 19481

## CERTIFICATE OF DEATH.

129

E 19481

1-PLACE OF DEATH 1646 N Smallwood St. 15-60

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

2-FULL NAME Thomas Patrick Muntz

(a) RESIDENCE No. 1646 N Smallwood ST., St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 ~~Single~~, Married, ~~Widowed, or Divorced, (write the word)~~: Married

5a If married, widowed, or divorced HUSBAND of (~~or WIFE of~~) Anna Delores

6 DATE OF BIRTH (month, day, and year) March 4 - 1879.

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 5-3 | 11 | 22 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Merchant. 045

(b) General nature of industry, business, or establishment in which employed (or employer): President

(c) Name of employer: Home Pie Bakery, Seneca. md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER: Thomas Muntz

11 BIRTHPLACE OF FATHER (city or town) (State or country): England.

12 MAIDEN NAME OF MOTHER: Mary Lyston

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant: Mary T. Muntz

(Address) 1905 16th St. Washington

FEB 27 1927 Filed ....., 19 ..... Registrar

Mitra Hearse Except - W. E. Humphreys.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan 30, 1927, to Feb 26, 1927,

that I last saw h~~im~~ alive on Feb 26, 1927,

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Parenchymatous Nephritis Acute

(duration) 0 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary Test

(Signed) E. Miles Wheeler, M. D.

Feb 27, 1927 (Address) 2129 Wyoming Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet - Washington D.C.

DATE OF BURIAL: 1-1-27

20 UNDERTAKER: Martin Fahey & Son.

ADDRESS: 1829 W North ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19432

## CERTIFICATE OF DEATH.

11-15 19 2

E 19432

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miguel Franco

(a) RESIDENCE NO. 917 N. Calvert St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| malw | white | single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 5/1905

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 22 | 0 | 20 ✓ 21 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrical Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) 30

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Columbia, South America

PARENTS

10 NAME OF FATHER Napolean Franco

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) South America

12 MAIDEN NAME OF MOTHER Rebecca DeFran

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) S.A.

14 Informant Hopkins Records

(Address)

Filed FEB 28 1927 C. HAMPSON JONES, M. Registrar

Per _____

### CORONER'S CERTIFICATE OF DEATH 26.

16 DATE OF DEATH (month, day, and year) Feb 26 27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

TOXEMIA from 2nd & 3rd degree burns. Accidentally burned from electric wire at Havana Cuba about 4 mons ago (duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) _____ (duration) ___ yrs. ___ mos. ___ ds.

(Signed) J. H. Blum M. D. (Coroner)

2/27/27 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Date of Burial 2/28/27

20 UNDERTAKER Joseph Abrams ADDRESS 221 Bway

This is a PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 19483

## CERTIFICATE OF DEATH

E 19483

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 550 Welcome St. 27-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Floyd Spence

(a) RESIDENCE NO. 550 Welcome St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 7 mos. 18 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: C

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): July - 8 1925

7 AGE: Years 1 Months 7 Days 18 IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Elijah Spence

11 BIRTHPLACE OF FATHER (City or town): Summerville

(State or country): S. Carolina

12 MAIDEN NAME OF MOTHER: Addie Spence

13 BIRTHPLACE OF MOTHER (city or town): Summerville

(State or country): S. Carolina

14 Informant: Elijah Spence

(Address): 550 Welcome St.

15 Filed FEB 28 1927 19 G. HAMPSON JONES, M. D. Registrar

Per R. H.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: Feb - 26 - 27

17 I HEREBY CERTIFY, That I attended deceased from 2/21, 19 27, to 2/26, 19 27, that I last saw him alive on 2/25, 19 27, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Acute Bronchopneumonia

Primary

(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Dan Trumbo, M. D.

2/26, 19 27 (Address) 122 W Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — Date of Burial: 2-28 1927

20 UNDERTAKER: John H. Toadvine — ADDRESS 1027 Hanover

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19484

## CERTIFICATE OF DEATH.

E 19484

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2008 Gough St. (WARD)

2-FULL NAME Rosalie Budzka

(a) RESIDENCE. No. 2008 Gough ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -

6 DATE OF BIRTH (month, day and year): April 1872

7 AGE: Years 54 | Months 10 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer -

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: Ignacy Wonalk

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Magajska

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Walter Budka (Address) 2008 Gough St

15 Filed FEB 28 1927 Per C. HAMILTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 26. 1927.

17 I HEREBY CERTIFY, That I attended deceased from Feb. 22, 1927, to Feb. 26, 1927, that I last saw h[illegible] alive on Feb. 25, 1927, and that death occurred, on the date stated above, at 4:35 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy (Hypertension & Arteriosclerosis)

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? residence

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. J. Deimler M. D.

Feb 1927 (Address) 2001 E. Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary | DATE OF BURIAL: March 1927

20 UNDERTAKER: L. W. Ozarowski | ADDRESS: 1930 Eastern

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 19485
1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

E 19485
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 520 Somerset St. 5-8 WARD)

2-FULL NAME Wm. Figy Jr.

(a) RESIDENCE NO. 520 Somerset ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): May 2, 1926

7 AGE — Years: — Months: 9 Days: 24

If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of Industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Wm Figy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Gertrude Lokerd

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Wm Figy Father 520 Somerset st

15 Filed FEB 28 1927. C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 26 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb 22, 1927, to Feb 26, 1927, that I last saw him alive on, Feb 25, 1927, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia (Primary)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) R J Young, M. D.

2/26, 1927 (Address) 14 Ly Environment

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Calvary. DATE OF BURIAL: 2/28/27

20 UNDERTAKER: Mrs P. G. Elliott ADDRESS: 1725 Oakland

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19486

100-001

E 19486

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Hamilton 3 — REGISTERED NO. .....

CITY OF BALTIMORE: (No. 5 Rockwood Ave ST. 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Elizabeth Kahl

(a) RESIDENCE NO. 5 Rockwood Ave ST., Hamilton WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female — 4 COLOR OR RACE: White — 5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George Kahl

6 DATE OF BIRTH (month, day, and year): June 23-1839

7 AGE — Years: 87 — Months: 8 — Days: 3 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Georges

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Uckrodon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. L. H. Lange

(Address) 5 Rockwood Ave

15 Filed FEB 28 1927 — Per ..... HAMPTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 26th 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb 20 1927 to Feb 26 1927

that I last saw h alive on Feb 25 1927

and that death occurred, on the date stated above, at 4:30 m.

The CAUSE OF DEATH* was as follows:

Pneumonia

Bronchial

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Fred T. Zimmerman M. D.

2/28 1927 (Address) 1058 Hamilton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Feb. 28, 1927

20 UNDERTAKER: Wm. J. Tickner Sons — ADDRESS: North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19487

## CERTIFICATE OF DEATH.

E 19487

1-PLACE OF DEATH Md. Gen. Hosp. REGISTERED NO. 11-002

CITY OF BALTIMORE: (NO. 2824 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Donald H. Thomas.

(a) RESIDENCE NO. 6011 Gwynn oak ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 10 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb. 17-1927

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 0 | 0 | 9 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md. Gen. Hosp. Balto Md.

PARENTS

10 NAME OF FATHER: Wallace Alex Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Clara Dowling

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Mrs Clara D Thomas

(Address) 6011 Gwynn oak ave

15 Filed FEB 28 1927 C. HAMPSON JONES, M. D. Registrar

Per R.R.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2-26 1927

17 I HEREBY CERTIFY, That I attended deceased from 2-17 1927 to 2-26 1927

that I last saw h im alive on 2-26 1927

and that death occurred, on the date stated above, at 3:20 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Pneumococcus)

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Jno A Simpson M. D.

, 19 (Address) Md Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem

DATE OF BURIAL: Feb 28 1927

20 UNDERTAKER: Wm J Rickter Sons

ADDRESS North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 19488 — E 19488

1-PLACE OF DEATH

CITY OF BALTIMORE: No. JOHNS HOPKINS HOSPITAL ST. 16-23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Conley

(a) RESIDENCE NO. 1204 Riggs Avenue Balto. Md WARD Virginia

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 5 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Col | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) Nov 1864

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min |
|---|---|---|---|---|
| 62 | | 3 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Alfred Hallin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Emma Hall

(Address) 1204 Riggs Ave

15 (Filed) FEB 28 1927 19 C. HAMPSON JONES, M. D. Registrar

FEB 29 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 · 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 23 . 1927 . to Feb 27 . 1927 .

that I last saw h er alive on Feb 27 . 1927

and that death occurred, on the date stated above, at 5.08 p m.

The CAUSE OF DEATH* was as follows:

(Primary) Pseudo Myxoma Peritonei.

(duration) 4 yrs mos ds.

CONTRIBUTORY (Secondary) Failed to rally after Operation

(duration) yrs mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Feb 26, 1927

Was there an autopsy? yes

What test confirmed diagnosis? Microscopic exam. of tissue

(Signed) Lawrence W. Smith, M. D.

, 19 (Address) Johns Hopkins Hospital Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL Feb 28 1927

20 UNDERTAKER Samuel Wright & Son ADDRESS Baltimore

Spec.-7-17-26—A Co.—200 Bks.

E 19489

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

+93

E 19489

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. University Hospital 4-30 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eleanor Brooks

(a) RESIDENCE NO. Camp Meade St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos 20 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | Black | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Married

6 DATE OF BIRTH (month, day, and year): dont know

| 7 AGE | Years | Months | Days | IF LESS than 1 day ...hrs. or ...min.. |
|---|---|---|---|---|
| About 29 yrs | | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Cairo Junc

(State or country) Md

PARENTS

10 NAME OF FATHER Charles Hurt

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Estel Gaither

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant (Address) Mrs Cairo Gaither Burkittsville Md

Filed FEB 28 1927 C. HAMPSON JONES, M. D.

Per [illegible] Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

February 27 - 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 1 1927 to Feb 27 1927

that I last saw h alive on Feb 26 1927

and that death occurred, on the date stated above, at 5 30 A m.

The CAUSE OF DEATH* was as follows:

Emboleism resulting from thrombo phlebitis of left leg

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pelvic Inflamatory Disease

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Phy Exam autopsy

(Signed) Knight Reynolds, M. D.

19 (Address) Community Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (3) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Md — Date of Burial: Mar 1927

20 UNDERTAKER: E. M. Fisher — ADDRESS: Ewell Md

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19490 E 19490

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Josephs Hospital

CITY OF BALTIMORE: (No. Caroline & Oliver ST. 16-67 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sylvester Farcena

(a) RESIDENCE NO. 1614 St Stevens ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 8 mos. — ds. How long in U. S., if of foreign birth? 30 yrs. — mos. — ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | white | Single — |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 22. 1884

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 43 | 0 | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy —

PARENTS

10 NAME OF FATHER Salvatore Farcena

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy.

12 MAIDEN NAME OF MOTHER Marie Maltadre

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy.

14 Informant (Address) Joseph Farcena Nephew Md.

15 Filed FEB 28 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 18 1927 to Feb 27 1927, that I last saw him alive on Feb 27 1927, and that death occurred, on the date stated above, at 5:50 a m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever.
Pulmonary Tbc.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no. What test confirmed diagnosis? Clinical.

(Signed) Frank G. DiSanto, M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery DATE OF BURIAL 2/28 1927

20 UNDERTAKER Chas F. Kraus & Son ADDRESS 118 W Mt Royal ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19491

E 19491

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 401 Bretton Place ST. 12-49 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia C. Finckenaur

(a) RESIDENCE No. 401 Bretton Place ST., ... WARD ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 96 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 7-1830

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs or ... min. |
|---|---|---|---|---|
| | 96 | 7 | 10 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ... retired

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md. ~~Henry Finckenaur~~ ~~Alsace Lorraine~~

PARENTS

10 NAME OF FATHER Henry Finckenaur

11 BIRTHPLACE OF FATHER (city or town) Alsace (State or country) Lorraine

12 MAIDEN NAME OF MOTHER Margaret Mauss

13 BIRTHPLACE OF MOTHER (city or town) ... (State or country) France

14 Informant M. Elizabeth Buzinger
(Address) 401 Bretton Place

15 Filed FEB 28 1927 by HAMPSON JONES, M. D. Registrar
Per ...

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 1927

17 I HEREBY CERTIFY, That I attended deceased from 1894. 19 ... to Feb 27 .1927.

that I last saw h alive on Feb 25 .1927.

and that death occurred, on the date stated above, at 4.20 a m.

The CAUSE OF DEATH* was as follows:

Senile heart

(duration) ? yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Edema of lungs

(duration) ... yrs. ... mos. 2 days ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) John Kutrick M. D.

Feb 27 1927 (Address) 11 E. Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Loudon Park. | Mch 1. 1927 |

| 20 UNDERTAKER | ADDRESS |
|---|---|
| John Ottobill | 800 Eutaw Place |

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 19492

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19492

## CERTIFICATE OF DEATH.

94 001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2027 Eutaw Place St. 14-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William R. Bartholomay

(a) RESIDENCE NO. 2027 Eutaw Place St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Henrietta A. Bartholomay

6 DATE OF BIRTH (month, day, and year): Dec. 1, 1862

7 AGE — Years: 64 Months: 2 Days: 24 If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Justus Bartholomay

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Anna Altman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Mrs. Henrietta A. Bartholomay 2027 Eutaw Place

15 Filed FEB 28 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 25, 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb 14, 1927, to Feby 25, 1927.

that I last saw him alive on Feby 25, 1927.

and that death occurred, on the date stated above, at 10 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Arteriosclerosis

Arteriosclerosis Cerebral Hemorrhage

(duration) yrs. 1 mos 6 ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical + Med History

(Signed) Jas L. Hooper, M. D.

2-27-1927 (Address) 962 W. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem.

DATE OF BURIAL: Feb. 28, 1927

20 UNDERTAKER: John C. Mitchell

ADDRESS: 1900 Eutaw Place

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 19493 | 129 E 19493

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 319 E. 25th St. 12-50 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Victoria Kramer

(a) RESIDENCE NO. 319 E. 25th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. — mos. — ds. How long in U. S., if of foreign birth? 51 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles W. Kramer

6 DATE OF BIRTH (month, day, and year) Aug 24 1856

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 70 | 6 | 2 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Kingston (State or country) Canada

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) unknown (State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown (State or country)

14 Informant Miss Kramer

(Address) 319 E. 25th St.

15 Filed ..... 19 .....

By ..... Registrar

C. HAMPSON JONES, M. D.

FEB 28 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2 - 26 1927

17 I HEREBY CERTIFY, That I attended deceased from 2 - 25 - 1927. to 2 - 26 1927.

that I last saw her alive on 2 - 26 1927

and that death occurred, on the date stated above, at 2 45 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Chr. Myo + endo - carditis

Chr Nephritis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? 319 W. 25th St.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Evidence.

(Signed) Geo. B. Dyhert, M. D.

, 19 (Address) 2802 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Green Mount | Mar 1, 1927 |
| 20 UNDERTAKER | ADDRESS |
| Rita Wiedefeld | 914 Greenmount Ave |

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19494

## CERTIFICATE OF DEATH.

17° E 19494

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1 PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hanson Memorial Hospital ST. (WARD)

2 FULL NAME Charles H. Lindemore

(a) RESIDENCE No. 3005 Road Road ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | W | Married |

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Lillie M. Lindemore

6 DATE OF BIRTH (month, day, and year) Jan 12 1897

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 30 | 1 | 12 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Sheet Metal Worker
(b) General nature of industry, business, or establishment in which employed (or employer) Penna R R
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

PARENTS

10 NAME OF FATHER James Lindemore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Schenck

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Earl M. Banks
(Address) 5008 Ross Road

15 Filed FEB 28 1927, 192 C. HAMPSON JONES, M. D. Registrar.

Per

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/24 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun Shot wound
Through head
Suicide

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Chas. Morrison M. D. (Coroner.)

2/25, 1927 (Address) 263 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL Feb 28 1927

20 UNDERTAKER De Le Roy Stiffler

ADDRESS 125 North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

## CERTIFICATE OF DEATH.

**E 19495** 1-PLACE OF DEATH

18-16

**E 19495** REGISTERED NO.

City of BALTIMORE: (No. 421 N. Carey St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eusebia I. Holschen

(a) RESIDENCE NO. 421 N. Carey St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. mos. (If non-resident give city or town and State) How long in U. S., if of foreign birth yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Otto B. Holschen

6 DATE OF BIRTH (month, day, and year) Nov. 10 1845

| 7 AGE | Years | Months | Days | IF LESS than 1 day ...hrs. or ...min. |
|---|---|---|---|---|
| | 81 | 3 | 16 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Clear Spring

(State or country) Md

PARENTS

10 NAME OF FATHER Wm C. Cochen

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Pa

12 MAIDEN NAME OF MOTHER Maria Guthrie

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Pa

14 Informant Harry A. Holschen

(Address) 421 N. Carey St

15 Filed ... 19... H. [illegible] Registrar

FEB 28 1927

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 26 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 24, 1927, to Feb. 26, 1927, that I last saw h.. alive on Feb. 26, 1927, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ...yrs. ...mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Eyes mostly

2/27, 1927 (Signed) Felix M. Villella, M. D.

(Address) 406 N. Carey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. Date of Burial Mar. 1 1927

20 UNDERTAKER Harry W. Ellen ADDRESS 1905 W. North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19496

## CERTIFICATE OF DEATH.

129

E 19496

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1137 N. Mount ST. 16-22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pauline Seabreeze

(a) RESIDENCE No. 1137 N. Mount ST., WARD Virginia

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed or divorced, HUSBAND of (or) WIFE of: Caleb Seabreeze

6 DATE OF BIRTH (month, day, and year):

7 AGE: Years 80 — Months — Days — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Spencer Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER:

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Charles Seabreeze.

(Address) 1137 N. Mount St.

Filed FEB 28 1927 J. HAMPSON JONES, M. D.

By Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 27 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 18, 1927, to Feb. 27, 1927, that I last saw her alive on Feb. 27, 1927, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

apoplexy

(duration) yrs. mos 2 da.

CONTRIBUTORY (Secondary) Diseases Chronic Nephritis + complication

(duration) 1 yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? Va.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Postive

(Signed) R. G. W. Kennard, M. D.

2-27 1927 (Address) 708 Encon St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Forth Thundland Co

DATE OF BURIAL: Mar 2 1927.

20 UNDERTAKER: Virginia G. Brooks

ADDRESS 1430 Carey

N. B. NAMES, correctly spelled, and full information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19497

## CERTIFICATE OF DEATH.

90 E 19497

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2206 Westwood St. 15-68 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Henry Marsden

(a) RESIDENCE NO. 2206 Westwood ST., 15th WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | married |

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Mary Marsden

6 DATE OF BIRTH (month, day, and year) 1-10-1845

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 82 | 1 | 16 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Patrolman 061

(b) General nature of industry, business, or establishment in which employed (or employer) Police Station

(c) Name of employer North Western District

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James Henry Marsden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary O'Brien

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mrs. Rodney Thomas

(Address) 418 E. 25th St

15 Filed FEB 28 1927, 19 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-26 1927

17 I HEREBY CERTIFY, That I attended deceased from April 5th, 1926, to Feb 25, 1927, that I last saw him alive on Feb 25, 1927, and that death occurred, on the date stated above, at 2. P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 10 mos ds.

CONTRIBUTORY (Secondary) Senility & age

(duration) yrs. 10 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Examination Heart & Symptoms

(Signed) Louis S. McCarrison, M. D.

, 19 (Address) 416 E North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 1-1-27 19

20 UNDERTAKER Martin Fahey & Sons

ADDRESS 132 N Howard

MED. WRITE PLAINLY, with unfading ink. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19498

## CERTIFICATE OF DEATH.

100-001

E 19498

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Josephs Hospital

CITY OF BALTIMORE: (No.) Caroline & Oliver ST. 1 7-25 (WARD)

2-FULL NAME Dominick Marisglia -

(a) RESIDENCE No. 420 N. Green St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 9 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): May 15-1925

7 AGE — Years: 1 — Months: 9 — Days: 10 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None -

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Joseph Marisglia

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Josefina Camaggio -

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Colorado.

14 Informant (Address): Joseph Marisglia 420 N Green St

15 Filed FEB 28 1927 19 Per

C. HAMPTON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 25 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb. 15, 1927, to Feb. 25, 1927, that I last saw him alive on Feb. 25, 1927, and that death occurred, on the date stated above, at 9:56 p.m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia -

(duration) yrs. 1 mos

CONTRIBUTORY (Secondary): Emfysema -

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? no - Date of —

Was there an autopsy? no -

What test confirmed diagnosis? clinical.

(Signed) Frank R. DiPaula, M.D.

, 19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: Feb 28 1927

20 UNDERTAKER: N. McRoutson — ADDRESS: 223 N Smith

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 19499

REGISTERED NO. 90 E 19499

1-PLACE OF DEATH

City of BALTIMORE: (No. 1305 N. Carey St. 11-19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susie Fisher

(a) RESIDENCE NO. 1305 N. Carey St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced (or) WIFE of George W Fisher

6 DATE OF BIRTH (month, day, and year) May 5, 1867

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min.. |
|---|---|---|---|---|
| | 59 | 9 | 21 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Pennsylvania

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) unknown

14 Informant Essie Fisher

(Address) 5803 Belloma Ave

15 Filed FEB 28 1927 C. HAMPSON JONES, M. D. Registrar

Per R K

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 26th 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 10th, 1927 to Feb 26th, 1927

that I last saw her alive on Feb 26 1927

and that death occurred, on the date stated above, at 1.45 P m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Oedema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis Arteriosclerosis

(duration) do not know yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) R L Kugler M. D.

, 19 (Address) Wentworth Apts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet

Date of Burial 3/1 1927

20 UNDERTAKER William Coote

ADDRESS 502 E Lex

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 19500

REGISTERED NO. 57 E 19500

1-PLACE OF DEATH

City of BALTIMORE: (No. 151 N Belvedere Ave St., 27-6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma L. Foster

(a) RESIDENCE NO. 151 N. Belvedere Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas A Foster

6 DATE OF BIRTH (month, day, and year): Oct 25, 1865

7 AGE: Years 58 Months 4 Days 1

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Balto

(State or country): Md

PARENTS

10 NAME OF FATHER: William Slater

11 BIRTHPLACE OF FATHER (City or town): Balto

(State or country): Md

12 MAIDEN NAME OF MOTHER: Anna M Sheridan

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country): Md

14 Informant: Thomas A Foster

(Address): 151 N Belvedere Ave

15 Filed ..... 19 ..... C. HAMPTON JONES, M. D. Registrar

Per .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 25 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 16 26, 19..., to Feb 25 27, 19...,

that I last saw h[illegible] alive on Feb 25 27, 19...,

and that death occurred, on the date stated above, at 9:15 P m.

The CAUSE OF DEATH* was as follows:

Diabetes.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

Arthritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

, 19 (Address) 506 Park Heights Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Lowe

Date of Burial: 2/28 1927

20 UNDERTAKER: J. H. Cook

ADDRESS: 1210 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FEB 28 1927

Spec.—7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19501

100-001

## CERTIFICATE OF DEATH

E 19501

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hospital St. 22-70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nathan Hogarth

(a) RESIDENCE NO. 3314 Frederick Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. da.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sallie Hogarth

6 DATE OF BIRTH (month, day, and year): Dec 14-1854

7 AGE: Years 69 Months 2 Days 8

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Supt. Con. Work

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: City.

9 BIRTHPLACE (city or town): Balto.

(State or country)

PARENTS

10 NAME OF FATHER: Alex. Hogarth

11 BIRTHPLACE OF FATHER (City or town): Md.

(State or country)

12 MAIDEN NAME OF MOTHER: Abilla Hanson

13 BIRTHPLACE OF MOTHER (city or town): Md

(State or country)

14 Informant: Mrs. Sallie Hogarth

(Address) 3B 14 Fred. Ave. City

15 Filed , 19 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-27 1927

17 I HEREBY CERTIFY, That I attended deceased from 2-23, 1927, to 2-27, 1927, that I last saw him alive on 2-27, 1927, and that death occurred, on the data stated above, at 11 53 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) W. Lee Brown, M. D.

, 19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount — Date of Burial: Mar 1 27

20 UNDERTAKER: [illegible] — ADDRESS: [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 19502

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19502

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2806 Edmondson Ave ST., WARD)

REGISTERED NO. 16-69 100-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo. H. Willgrubs

(a) RESIDENCE NO. 2806 Edmondson Ave ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. 8 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna M. Willgrubs

6 DATE OF BIRTH (month, day, and year): June 15th 1880

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 46 | 8 | 10 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machinist

(b) General nature of industry, business, or establishment in which employed (or employer): 031

(c) Name of employer: B. C. A. A.

9 BIRTHPLACE (City or town) (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER: Ulrich Willgrubs

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Emma Crenel

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Germany

14 Informant: Fred Gutner (Address) 2806 Edmondson Ave

15 Filed ..... 19 ..... Registrar H. Hampson Jones, M. D.

Per .....

FEB 26 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 25th 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 21, 1927, to Feb. 25, 1927, that I last saw h[illegible] alive on Feb. 25, 1927, and that death occurred, on the date stated above, at 5.45 a m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic Lobar Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. C. Hennessy, M. D.

Feb 26, 19 27 (Address) 2502 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Feb 28 1927

20 UNDERTAKER: F. D. Neufeldt — ADDRESS: 1854 W Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19503

## CERTIFICATE OF DEATH.

101-001

E 19503

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1829 W Lanvale St. 15-21 Ward)

2-FULL NAME William Thurmon Mabel

(a) RESIDENCE NO. 1829 W Pressstmen St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: C

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rebecca Cummings Mabel

6 DATE OF BIRTH (month, day, and year): Feb 7, 1890

7 AGE — Years: 37 | Months: 0 | Days: 17 | If LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Odd

(c) Name of employer

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER: Charles Mabel

11 BIRTHPLACE OF FATHER (city or town): Baltimore Md

(State or country)

12 MAIDEN NAME OF MOTHER: Elizabeth Hooker Walker

13 BIRTHPLACE OF MOTHER (city or town): Baltimore

(State or country)

14 Informant: Elizabeth Walker

(Address) 1829 W. Lanvale St City

FEB 26 1927

C. HARRISON JONES, M. D.

Filed ..... 19 .....

By ..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 24 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 20 1927 to Feb 24 1927, that I last saw h[illegible] alive on Feb 24 1927, and that death occurred, on the date stated above, at 11 00 P m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) J. W. Holden M. D.

Feb 27, 1927 (Address) 1829 Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — Date of Burial: Feb 28, 27

20 UNDERTAKER: Edward Bryan — ADDRESS 1031 orleans st

Spec.-7-17-26-A Co.-200 Bks.

E 19504

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

100-001

E 19504

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1621 Madison Ave. St.) (Ward) 14-20

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Aster May Spratley

(a) RESIDENCE NO. 1621 Madison Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 26. 1926

7 AGE Years: 5 Months: Days: 20 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Wm Homer

11 BIRTHPLACE OF FATHER (City or town) (State or country): Gladstone Va

12 MAIDEN NAME OF MOTHER: Lavina Spratley

13 BIRTHPLACE OF MOTHER (city, or town) (State or country): Prince George Md

14 Informant: Lavina Spratley

(Address): 1621 Madison Ave

FEB 28 1927

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-26 1927

I HEREBY CERTIFY, That I attended deceased from Feb. 25 1927, to Feb 26 1927, that I last saw h— alive on Feb 26 1927, and that death occurred on the date stated above, at 4.40 a.m.

The CAUSE OF DEATH was as follows: Bronchopneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) O. Garland Chrisman M. D.

Feb 28 1927 (Address) 1534 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: D.H. Auburn Cem

Date of Burial: 3/2 1927

20 UNDERTAKER: Samuel Hemsley

ADDRESS: 1758

HAMPSON JONES, M.D.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

E 19505

1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

E 19505

REGISTERED NO.

City of BALTIMORE: (No. 1549 Lesliest. St. 15-21 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Taylor

(a) RESIDENCE NO. 1549 Lesliest. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah Taylor.

6 DATE OF BIRTH (month, day, and year): March 2, 1884

7 AGE: Years 42 Months 11 Days 24 IF LESS than 1 day ....hrs. or 28 ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): General

(c) Name of employer

9 BIRTHPLACE (city or town): Va

(State or country)

PARENTS

10 NAME OF FATHER "Bessy" Taylor

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Jackson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant: Mrs. Robt. Taylor

(Address) 1549 Lesliest.

15 Filed FEB 28 1927 19 M. M. JONES M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 26, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) no other history

(duration) yrs. mos. ds.

(Signed) J. T. Heuisler, M. D.

(Coroner)

Feb. 27 1927 (Address) 2807 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mems Mfg Co — Date of Burial: Feb 28 1927

20 UNDERTAKER: Sam'l M. Chase & Son — ADDRESS: 1400 Mosher

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19506

## CERTIFICATE OF DEATH.

101-001

E 19506

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 905 N. Stricker St. 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Benson E. Rawlings

(a) RESIDENCE NO. 905 N. Stricker St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | colored | single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 14, 1893

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 34 | | 9 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer General

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Benson Rawlings

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Coates

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Sarah Rawlings

(Address) 905 N. Stricker St.

Filed FEB 26 1927 HAMPSON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Feb. 25, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest

(Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said inquest

(Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Heart Disease

(duration) yrs. mos. ds.

(Signed) J. T. Kennedy M. D.
(Coroner)

Feb. 26, 1927 (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL W. Auburn — Date of Burial Feb 28 1927

20 UNDERTAKER Sam'l. H. Chase & Son — ADDRESS 1400 Madison

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19507

## CERTIFICATE OF DEATH.

100-001

E 19507

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 645 George St. St. 17-25 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Earl Tate

(a) RESIDENCE NO. 645 George St. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | colored | single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 26, 1925

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 1 | 9 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER James Tate

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Ellen Bruce

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Ellen Tate

(Address) 645 George St.

15 Filed FEB 28 1927, 19 E. HAMPTON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 26, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Measles

(duration) yrs. mos. ds.

(Signed) E. E. Hennessy M. D.

(Coroner)

2/26, 1927 (Address) 280 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. Date of Burial March 1 1927

20 UNDERTAKER Daniel Gorsuch ADDRESS 916 Pa Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19508

## CERTIFICATE OF DEATH.

E 19508

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 837 Ostend St. (ST.) 21-29 (WARD) 57

2-FULL NAME Ruth Williams

(a) RESIDENCE NO. 837 Ostend ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 ~~Single~~, Married, Widowed, or ~~Divorced~~ (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: [illegible]

6 DATE OF BIRTH (month, day, and year): 1867

7 AGE: Years 60 | Months | Days | If LESS than 1 day, ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Richmond Va

PARENTS

10 NAME OF FATHER: [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Ella Cooper

(Address) 837 Ostend St

15 FEB 28 1927 H. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2-25-1927

17 I HEREBY CERTIFY, That I attended deceased from 2-23, 1927, to 2-25, 1927, that I last saw her alive on 2-25, 1927, and that death occurred, on the date stated above, at 4 4 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Diabetes

(duration) ..... yrs. 1 mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Herbert Dorsey, M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: Feb 26 1927

UNDERTAKER: Harold Corbin — ADDRESS: [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 19509 ✓

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

11-001

E ~~19509~~ 19509

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

E ~~19509~~ OF DEATH

City of BALTIMORE: (No. 1010 Warner St. 21-31 Ward)

2-FULL NAME Emmett Smith

(a) RESIDENCE NO. 1010 Warner St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5y yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 19 1925

7 AGE: Years 1 Months 8 Days 7 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Page Smith

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Smith

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Kent Island Md.

14 Informant Dewey Lee

(Address) 1010 Warner St

15 Filed FEB 28 1927, 19 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 Feb. 26

17

I HEREBY CERTIFY, That I attended deceased from Feb 16, 1927, to Feb 26, 1927, that I last saw h.. alive on Feb 26, 1927, and that death occurred, on the date stated above, at 7.50 P. m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) D. H. Campbell M. D.

2/26 1927 (Address) 805 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Ct. Date of Burial Feb 28 1927

20 UNDERTAKER: H. C. Brown & Son ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 19510

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

91-092

E 19510

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. ) (ST., ) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Giot

(a) RESIDENCE NO. 5312 Maple Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1863

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs or ... min. |
|---|---|---|---|---|
| | 64 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar Manufacturer

(b) General nature of industry, business, or establishment in which employed (or employer) Cigars

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland Unknown

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do Do

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Baltimore City Hospitals (Address)

15 Date FEB 28 1927 G. HAMPTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 26, 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 9, 1927, to Feb. 26, 1927, that I last saw him alive on Feb. 26, 1927 and that death occurred, on the date stated above, at 2:55 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pyorrhoea and Chronic Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Henry Fleming M. D.

2/27/27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westminster Cemetery — DATE OF BURIAL Mar 1 1927

20 UNDERTAKER Josiah Syfer — ADDRESS 1600 W Baltimore Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 19511

66 E 19511

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1724 Church Ct. St., ____ Ward) near Greenmount Ave

2-FULL NAME Harry L. Long

(a) RESIDENCE NO. Court Court St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred __ yrs. __ mos. __ ds. How long in U. S., if of foreign birth? __ yrs. __ mos. __ ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single (D. N.)

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 12/884

7 AGE 42 Years | Months 11 | Days 12 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER John Long

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Caroline Ullman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Chas. Long Jr.

(Address) 1712 Durham St.

15 Filed FEB 28 1927 19 C. HAMILTON JONES, M. D. Registrar

By: _____

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 26, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute alcoholism (Wood alcohol)

(duration) __ yrs. __ mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) __ yrs. __ mos. __ ds.

(Signed) J. T. Kennedy, M. D. (Coroner)

2/24, 1927 (Address) 2807 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death __ yrs. __ mos. __ ds. In the State __ yrs. __ mos. __ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Conn — Date of Burial: March 1927

20 UNDERTAKER: David Easton — ADDRESS: 516 Ca ave

N.B.—WRITE PLAINLY, WITH INFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 19512 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. E 19512

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2328 Guilford av ST. 12-50 WARD)

2-FULL NAME Warren ~~Russell~~ Burrell.

(a) RESIDENCE NO. 2328 Guilford ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | C | Widower |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widower

6 DATE OF BIRTH (month, day, and year) ~~January~~ August 1862

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 65 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer - Oil

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Ora Thompson

(Address) 2328 Guilford ave

FEB 28 1927

15 Filed HAMPSON JONES, M. D.

Per Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/25 1927

17 I HEREBY CERTIFY, That I attended deceased from 2/25 1927 to 2/25 1927

that I last saw him alive on 2/25 1927

and that death occurred, on the date stated above, at 6 00 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Hampton Jones, M. D.

2/26 1927 (Address) 2328 Guilford ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Glen Burnie Md

DATE OF BURIAL 2/28/27

20 UNDERTAKER Mrs. R. H. Elliott

ADDRESS 172 Oakland

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 19513 HEALTH DEPARTMENT—CITY OF BALTIMORE E 19513

CERTIFICATE OF DEATH. 11-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1218 N. Spring St.) (1013 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard Braun

(a) RESIDENCE. NO. 1218 N. Spring ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | C | single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 25 1906

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| 20 | 20/12 | 4 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer do

(b) General nature of industry, business, or establishment in which employed (or employer) Bethlehem

(c) Name of employer Steel Co.

9 BIRTHPLACE (city or town) (State or country) Kingston N.C.

PARENTS

10 NAME OF FATHER Wm Braun

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Bonnie Fenlow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Annie Braun
(Address) 1218 N. Spring st.

15 Filed . 19 C. HAMPSON JONES, M. D. Registrar

FEB 26 1927 Per

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 21 . 1927. to Feb 25 . 1927.
that I last saw him alive on Feb 25 . 1927.
and that death occurred, on the date stated above, at 1 P. m.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Sparrows Pt

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis? Symptoms

(Signed) Thos J Wooldridge, M. D.

2-25 1927 (Address) 703 W Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Kingston N. C. | 2/28/27 |

20 UNDERTAKER Mrs P. A. Elliott ADDRESS 1115 Ashland

THIS IS A LEGAL RECORD. WRITE CAREFULLY AND IN INK—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19514

## CERTIFICATE OF DEATH

E 19514

REGISTERED NO.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

City of BALTIMORE: (No. Provident Hospital St. 1924 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Statham

(a) RESIDENCE NO. Spanows Pt - 8&6 North side Barracks St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): S.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1908

7 AGE Years: 19 Months: Days: IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particolar kind of work: Lab. Gen

(b) General natore of industry, business, or establishment in whieh employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (City or town) (State or country): Va

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant (Address): Wm. Statham Spa Pt. Barracks

Filed FEB 28 1927 H. HAMPSON JONES, M. D. Registrar

Per KK

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/27/27. 19

17 I HEREBY CERTIFY, That I attended deceased from 2/22/27 19 to 2/27/27 19, that I last saw h. him alive on 2/27/27 19, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Acute dilatation of heart

(duration) Unknown

18 Where was disease contracted if not at place of death? Spanows Pt Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. L. Thomas, M. D.

19 (Address) 1012 Dr Spanows Pt Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Soicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Md — Date of Burial: 2/28/27

20 UNDERTAKER: Mrs B. T. Elliott — ADDRESS: 1125 Park Ave

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

113

E 19515

REGISTERED NO. E 19515

1-PLACE OF DEATH

City of BALTIMORE: (No. 117 N Bradford St., 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John B. Ritger

(a) RESIDENCE NO. 117 N Bradford St. 6 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 4 mos. 15 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 10th 1925

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 1 | 4 | 15 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER George L. Ritger

11 BIRTHPLACE OF FATHER (City or town) Balto. Md.

(State or country)

12 MAIDEN NAME OF MOTHER Ada Vernon

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.

(State or country)

14 Informant George L. Ritger (Father)

(Address) 117 N. Bradford St

Filed FEB 28 1927 19 C. HAMPTON JONES, M. D. Registrar

By R K

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 25 19 27

17 I HEREBY CERTIFY, That I attended deceased from Jan 24, 1927, to Feb 25, 1927.

That I last saw him alive on Feb 25, 1927.

and that death occurred, on the date stated above, at 11:35 P.M.

The CAUSE OF DEATH* was as follows:

Intestinal Rickets.

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) C. L. Lawson

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Phy Exam

Signed C. C. Lawson, M. D.

Feb 26 19 27 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

Date of Burial Feb 28 1927

20 UNDERTAKER Lilly & Zeiler

ADDRESS 403 S Mont St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19516

## CERTIFICATE OF DEATH.

90E 19516

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 440 E. Fort Ave. ST. 24-33 WARD)

2-FULL NAME Lemuel M. Gill.

(a) RESIDENCE NO. 440 E. Fort Ave. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 71 yrs. 1 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male. | White. | Married |

5a If married, widowed, or divorced, HUSBAND of Maggie Gill.

6 DATE OF BIRTH (month, day, and year) Jany. 8, 1856

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 71 | 1 | 17 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired watchman.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Jabez M. Gill.

11 BIRTHPLACE OF FATHER (city or town) (State or country) England.

12 MAIDEN NAME OF MOTHER Elizabeth Stansbury.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Holand.

14 Informant Maggie Gill. (wife)

(Address) 440 E. Fort Ave.

15 Filed FEB 28 1927 J. C. HAMPTON JONES, M. D. Registrar

Per R.M.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 25, 27

17

I HEREBY CERTIFY, That I attended deceased from February 21st, 19 27 to February 25, 1927

that I last saw him alive on February 25, 1927

and that death occurred, on the date stated above, at 10 p. m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of the Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency.

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? --------

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical diagnosis.

(Signed) Otto M Reinhardt, M. D.

(Address) 1017 E. Charles St. 2/26/27

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL Feb. 28 1927

20 UNDERTAKER John F. Denny — ADDRESS 715 Light

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

Margaret B. McGrath. ✓

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 19517 (1929) E 19517

1-PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 407 E. Lanvale ST.) 11-24 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Thomas McGrath

(a) RESIDENCE NO. 407 E. Lanvale ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of or) WIFE of Mr Thomas McGrath

6 DATE OF BIRTH (month, day, and year) [illegible]

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 58 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Mr Thos McGrath

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Miss Margaret Bracken

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Thomas McGrath 407 E. Lanvale St.

15 Filed FEB 28 1927 Per [illegible] C. HAMPSON JONES, M. D. Registrar

OK

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 25th 1927

17

I HEREBY CERTIFY, That I attended deceased from 2-9th, 1927, to Feb. 25th, 1927.

that I last saw her alive on Feb. 25th, 1927.

and that death occurred, on the date stated above, at 3:45 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis (Chs).

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Arthur C. Monniger M. D.

2-25, 1927 (Address) 323 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem. — DATE OF BURIAL 3/1/27

20 UNDERTAKER Mary M. Wiedefeld — ADDRESS 504 E 22d St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

E 19518

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

× 49 E 19518

1-PLACE OF DEATH The Church Home & Infirmary 6-9

City of BALTIMORE: (No. ____ St., 6-9 Ward)

REGISTERED NO. ____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Tucker Mrs. Georgia

(a) RESIDENCE NO. Delta, Pa. St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. 7 ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 Color or Race White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Tucker

6 DATE OF BIRTH (month, day, and year) Date Known

7 AGE Years 72 | Months | Days | IF LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ____

(State or country) Harford Co Md.

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) ____

(State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) ____

(State or country) Not Known

14 Informant Hospital Record

(Address)

15 Filed ____ 19 ____ Per ____ Registrar

C. HAMPSON JONES, M. D.

FEB 28 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-28-1927

17 I HEREBY CERTIFY, That I attended deceased from 2-21, 1927, to 2-28, 1927, that I last saw h[e] or alive on 2-28, 1927, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma urinary bladder.

(duration) ? yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) ____

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted, if not at place of death? Home.

Did an operation precede death? No Date of ____

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Nancy L. Wilson Dr., M. D.

, 19 (Address) The Church Home & Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Delta. Pa. Date of Burial 2-28. 1927

20 UNDERTAKER Ellis Hall ADDRESS 112 E Main St

IMPORTANT: The information called for in this certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 19519 — REGISTERED NO. E 19519

1-PLACE OF DEATH Mercy Hospital

City of BALTIMORE: (No. ____ St. 4-7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Johnson

(a) RESIDENCE NO. Nelson St. Mary's Co. Md. Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F. | Colored. | — |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 7 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ____

(c) Name of employer ____

9 BIRTHPLACE (city or town) ____

(State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) ____

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ____

(State or country) Unknown

14 Informant Mercy Hospt Records

(Address) ____

Filed FEB 28 1927 HAMPSON JONES, M. D. Registrar

Per R.K.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 27 1927

17 I HEREBY CERTIFY, That I attended deceased from 6/23/26, 1926, to Feb. 27, 1927 that I last saw h[illegible] alive on Feb. 27, 1927 and that death occurred, on the date stated above, at 2 50 P. m.

The CAUSE OF DEATH* was as follows: Pott's Disease

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) T.B. Meningitis

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? ____

Did an operation precede death? ____ Date of ____

Was there an autopsy? ____

What test confirmed diagnosis? ____

(Signed) E. Symolka, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart — Date of Burial 2/28 1927

20 UNDERTAKER D J Fahey Son — ADDRESS 13 Light St

---

IMPORTANT. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19520 — CERTIFICATE OF DEATH. — E 19520

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 7 Fifth Ave (St.) Highlandtown (No.) 3 (WARD)

2-FULL NAME Andrew Hermann Henkam

(a) RESIDENCE NO. 7 Fifth Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single — |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 30, 1914

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or ..... min. |
|---|---|---|---|---|
| | 12 | 6 | 28 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co.

PARENTS

10 NAME OF FATHER John A. Henkam

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Elizabeth Maher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Co.

14 Informant Andrew Henkam

(Address) 7 5th Ave

Filed FEB 28 1927 C. HAMPSON JONES, M. D. Registrar

Per [illegible]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/27 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 15 . 1927 . to Feb. 27 . 1927 .

that I last saw him alive on 2/22 . 1927 .

and that death occurred, on the date stated above, at 6a . m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Chest

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) H S Gittings — M. D.

2/27/27 (Address) 622 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cath. Woods DATE OF BURIAL 1927

20 UNDERTAKER: Lilly & Zeiler Co ADDRESS 402 S. Gay St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS STATEMENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

11-001

E 19521

## CERTIFICATE OF DEATH.

E 19521

1-PLACE OF DEATH

City of BALTIMORE: (No. 1025 E. Madison St St. 10-14 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Hester Monroe

(a) RESIDENCE NO. 1025 E. Madison St St._____ Ward_____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | col | widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. Monroe

6 DATE OF BIRTH (month, day, and year) June 16/1867

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 59 | 8 | 9 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 0

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) Snow Hill, Md.

PARENTS

10 NAME OF FATHER xxxxxxx Selby

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Snow Hill Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country)

14 Informant Roland B. Johnson (nephew)

(Address) 1710 Ashland Ave

FEB 28 1927

15 Filed _____ 19____ C. HAMPSON JONES, M. D. Registrar

Per R.R.

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25/27 19__

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Pneumonia

_____ (duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Possible Influenza

_____ (duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. H. Paca M. D.
(Coroner)

2/26/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ____ yrs., ____ mos., ____ ds. In the State ____ yrs., ____ mos., ____ ds.

Where was disease contracted, if not at place of death?_____

Former or usual residence_____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem Date of Burial 3/1 19 27

20 UNDERTAKER Bolton & Knight ADDRESS 1218 McElderry St

If death occurred in a hospital or institution should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

# E 19522

CERTIFICATE OF DEATH.

# E 19522

36-037

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. (or R. F. D.) Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Kleine

(a) RESIDENCE NO. North Point Road Bear Creek St. Baltimore Co. Md. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1916

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| 11 | 10 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Joe Kleine

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Hospital Records

(Address)

B 28 1927 C. HAMPSON JONES, M. D.

Registrar

Par

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 February 27, 1927

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1926, to February 27, 1927, that I last saw him alive on February 27, 1927, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of lungs

Tuberculous ulcers of intestines

Generalized amyloid infiltration

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) W. E. Hattens, M. D.

2-28 1927 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery Date of Burial Mch 1 1927

20 UNDERTAKER Hughes & Headley ADDRESS Dept Body

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 19523

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19523

## CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Balto General St. Hosp. WARD) 67

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Annie M. Nixon

(a) RESIDENCE NO. 1208 Franklin Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Nixon

6 DATE OF BIRTH (month, day, and year) May 28, 1873

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| 54 | 53 | 9 | xxx | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: James Busby

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Annie M. Nixon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: John Nixon

(Address): 1208 Franklin Rd.

15 2 8 1927 C. HAMPSON JONES, M. D. Per ARS Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/28 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 26, 1927, to Feb 28, 1927, that I last saw her alive on Feb 28, 1927, and that death occurred, on the date stated above, at 4:15 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio sclerosis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin. Exam.

(Signed) Amos L. Ensor, M. D.

2/28, 1927 (Address) Wil. Med. Gen. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: Mar. 2 1927

20 UNDERTAKER: Joseph B Cook

ADDRESS: 1003 Madison

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

# E 19524

CERTIFICATE OF DEATH.

185 E 19524

1-PLACE OF DEATH Mercy Hospital

REGISTERED NO.

City of BALTIMORE: (No. N. Calvert St. St., 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ~~Mallnday Annie Nix~~

(a) RESIDENCE NO. 187 N. Milton Av. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Conrad Nix

6 DATE OF BIRTH (month, day, and year): October 1, 1850

7 AGE: Years 76 | Months 4 | Days 25 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore,

(State or country): Maryland

PARENTS

10 NAME OF FATHER: George Waltz,

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Germany

14 Informant: George Nix

(Address): 1115 N. Patterson Pk. Ave.

15 Filed [illegible] C. HAMPSON JO[illegible] M. D. Registrar

Per [illegible]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 26 1927

17 I HEREBY CERTIFY, That I attended deceased from August 25 1926 to Feb. 26, 1927, that I last saw h[illegible] alive on Feb 26, 1927, and that death occurred, on the date stated above, at 5:45 A. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Sinuitis Unknown Fract. Left femur.

(duration) yrs. mos. ds.

18 Where was disease contracted (over)

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) P. M. Motta, M. D.

2-26. 1927 (Address) Mercy Hospital —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — Date of Burial: Mar. 1 1927

20 UNDERTAKER: Joseph B Cook — ADDRESS: 1003 W Balto St

should be stated EXACTLY. PHYSICIANS should state C[illegible] tion should be carefully supplied. AGE should be OF DEATH in plain terms, so that it may be p very important. See instructions on back of c[illegible] be properly classified. Exact statement of OCCUPA[illegible] of certificates.

MAR 2 1927

Spec.—1-12-23—M&T—500 Blks.

E 19525

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19525

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST., 7-10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest Langhans.

(a) RESIDENCE NO. 511 N. Madeira St ST., ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 10 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | white | single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 25, 1922

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 4 | 10 | 3 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Ernest Langhans

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Mary Rozicka

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs. Ernest Langhans

(Address) 511 N madeira St

15 Filed ..... 19 C. HAMPSON JONES, M. D. Registrar

8 28 1927 Per .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 27 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 27, 1927, to Feb 27, 1927, that I last saw him alive on Feb. 27, 1927 and that death occurred, on the date stated above, at 1045 p m.

The CAUSE OF DEATH* was as follows:

Tonsillar Pharyngeal & Laryngeal Diphtheria

(duration) ... yrs. ... mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis Clinical & Lab Test

(Signed) Myron G. Tull, M. D.

2/28. 1927 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Feb 28 1927

20 UNDERTAKER Frank E Crooke Co — ADDRESS 1906 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

E 19526 HEALTH DEPARTMENT—CITY OF BALTIMORE E 19526

89

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1531 N. Edrus St. 9-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mr. Ferdinand Ed. Elgert

(Residence in Baltimore: No. 1531 N. Edrus St.: 59 yrs., ..... mos. ..... ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Sept 4, 1867 (Month) (Day) (Year)

7-AGE, 59 yrs. 5 mos. 23 ds. If LESS than 1 day, .... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)..... Newspaper

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, John Elgert

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Catherine Stoos

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Ella Elgert

(Address) 1531 N. Edrus st

15-

Filed FEB 28 1927 C. HAMPSON JONES, M. D. Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 27, 1927 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 13 1927, to Feb 27 1927, that I saw him alive on Feb 23 1927, and that death occurred, on the date stated above, at 7 30 m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Augustus Zeller M. D.

2/28, 1927. (Address) 2939 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cemetery — DATE OF BURIAL, Mch. 2, 1927

20-UNDERTAKER F. A. Kramer & Co — ADDRESS 703 S. Howard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 19527

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90

E 19527

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1530 Park Ave ST. 14-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francese Litchfield Turnbull

(a) RESIDENCE No. 1530 Park Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): Widow

5a If ~~married~~, widowed, or ~~divorced~~ ~~HUSBAND OF~~ (or) WIFE of Late Lawrence Turnbull

6 DATE OF BIRTH (month, day, and year) May 23rd 1844

7 AGE: Years 82 | Months 10 | Days 5 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): New York

PARENTS

10 NAME OF FATHER: Irvin b Litchfield

11 BIRTHPLACE OF FATHER (city or town) (State or country): New York

12 MAIDEN NAME OF MOTHER: Grace Hubbard

13 BIRTHPLACE OF MOTHER (city or town) (State or country): New York

14 Informant: Lawrence Turnbull

(Address) 1530 Park Ave

15 FILED 3 28 1927 C. HAMPSON JONES, M. D. Registrar

By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28th 1927

17 I HEREBY CERTIFY, That I attended deceased from Feby 24 - 1927 to Feby 28 1927.

that I last saw h~~e~~r alive on Feby 27 1927

and that death occurred, on the date stated above, at 9 AM

The CAUSE OF DEATH* was as follows:

Myocarditis —

(duration) Several yrs. — mos — ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? None

(Signed) Chas Greenfield, M. D.

Feb 28 1927 (Address) 1327 Park Ave Baltimore

(*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem

DATE OF BURIAL: March 2 1927

20 UNDERTAKER: Henry H Perkins & Son Co

ADDRESS: Eutaw & Mulberry Sts

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXCEPTION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 19528

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19528

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 53 n Gilmor ST. 19-27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sallie C. Parker

(a) RESIDENCE NO. 53 n Gilmor ST. WARD S. Carolina

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred —yrs. mos. 30 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced (of) WIFE of J. C. Parker

6 DATE OF BIRTH (month, day, and year) unknown

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or min. |
|---|---|---|---|---|
| Abut | 45 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerg 018

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Joan S. C.

PARENTS

10 NAME OF FATHER Joseph P. Stevens

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Carolina

12 MAIDEN NAME OF MOTHER Mary C. Elliott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Joan S. Carolina

14 Informant R. B. Stephens

(Address) 107 n. Pearson Raleigh

15 1927 C. HAMPSON JONES, M. D. Registrar

BY

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 19, 1927, to Feb 28, 1927, that I last saw her alive on Feb 27, 1927, and that death occurred, on the date stated above, at 8 30 a m.

The CAUSE OF DEATH* was as follows:

Capilliary Bronchitis

Double pneumonia not TB

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) Chronic Parenchymatous nephritis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

19 (Signed) Blanche F. Ernst, M. D.

(Address) 707 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fort S. Carolina

DATE OF BURIAL 2/28 1927

20 UNDERTAKER Wellain Cook

ADDRESS 502 E North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

2 8 1927

Spec.—1-10-21—M&T—1500 Blks.

(Charles F. Lambert)

# HEALTH DEPARTMENT—CITY OF BALTIMORE

19529 E 19529

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Howard A Kelly Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 1418 Eutaw Place ST. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Charles F. Lambert

(a) RESIDENCE NO. North Fork W. Va. ST. WARD
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | white | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ruth Lambert

6 DATE OF BIRTH (month, day, and year) unknown 1881

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or min. |
|---|---|---|---|---|
| | 45 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Department Store

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) McDowell Co W. Va

PARENTS

10 NAME OF FATHER Thomas R. Lambert

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va

12 MAIDEN NAME OF MOTHER Mary Bailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va

14 Informant E. R. Lambert (Address) Pittsburgh Pa

15 Filed 2 8 1927 C. HAMPSON JONES, M. D. Registrar

Par

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 21, 1927, to Feb 28, 1927, that I last saw h[illegible] alive on Feb 28, 1927, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma testicle

Mountain (duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia Influenzal (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes. Date of Feb 1 '27

Was there an autopsy? no

What test confirmed diagnosis? Tissue Exam

(Signed) Grant E. Ward, M. D.

, 19 (Address) 1418 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Bluefield W. Va DATE OF BURIAL Feb 28 1927

20 UNDERTAKER Chas. G. Black ADDRESS 742 Wood St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CONDITION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

E 19530 HEALTH DEPARTMENT—CITY OF BALTIMORE E 19530

# CERTIFICATE OF DEATH.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2520 E Federal St. (Ward) 8-16

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlotte Rebecca Eyler

(a) RESIDENCE. No. 2520 E Federal St., Ward New Windsor Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Peter H. Eyler

6 DATE OF BIRTH (month, day, and year): Dec 8 1859

7 AGE: Years 68 | Months 2 | Days 20 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Ezekiel Malloy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary Pitcher

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Dora E. Warner New Windsor Md

Filed 2-28-1927 C. HAMPSON JONES, M. D. Registrar

By ACH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 28 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 25, 1927 to Feb 28, 1927.

that I last saw her alive on Feb 28 1927.

and that death occurred, on the date stated above, at 12 M. p. m.

The CAUSE OF DEATH* was as follows:

Cardiac & Respiratory Paralysis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Myocardial Degeneration

(duration) yrs. mos 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Frederick B. Kenard, M. D.

Feb. 28, 1927 (Address) 130 N Pat St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Beverdam Md. DATE OF BURIAL: March 1927

20 UNDERTAKER: Lit, Bixler New Windsor Md ADDRESS

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19531

E 19531

## CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1018 Madison ave ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bradley E Selden

(a) RESIDENCE NO. 1018 Madison ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ernest Selden

6 DATE OF BIRTH (month, day, and year): 1884

7 AGE — Years: 43 — Months: — Days: — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House maid

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Atlantic City Hotel

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): "

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): XX

14 Informant (Address): Ernest Selden 1018 Madison ave

15 Filed 2 8 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 27 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 18 1927 to Feb 27 1927.

that I last saw her alive on Feb 26 1927

and that death occurred, on the date stated above, at 9 20 A m.

The CAUSE OF DEATH* was as follows:

1 Pulmonary Tuberculosis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. 6 mos ds.

18 Where was disease contracted if not at place of death? Atlantic City N J

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Jr H Wright M. D.

Feb 28 1927 (Address) 1209 Preston ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: March 3 1927

20 UNDERTAKER: Wm H Chase Son — ADDRESS: 1400 Madison

INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

# E 19532

## CERTIFICATE OF DEATH.

# E 19532

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2914 Riggs Ave. St. 16-67 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Henry Weller

(a) RESIDENCE NO. 2914 Riggs Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Weller

6 DATE OF BIRTH (month, day, and year) October 30 1851

| 7 AGE Years | Months | Days | IF LESS than 1 day ...hrs. or ...min. |
|---|---|---|---|
| 75 | 3 4 | 27 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of indusiry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, MD

PARENTS

10 NAME OF FATHER Herman H. Weller

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary E. Spindler

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs Mary E. Weller

(Address) 2914 Riggs Ave

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Febuary 27, 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 23 1927, to Feb 27, 1927, that I last saw h-im alive on Feb 27, 1927, and that death occurred, on the date stated above, at 6 35 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) 1 yrs. 1 mos. 1 ds.

15 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Chas Egan & John H. Logan M.D.

Signed) 7/28. 1927 (Address) 1219 Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — Date of Burial: March 2 1927

20 UNDERTAKER: Jos Joerdens & Son — ADDRESS: 217 S. Paca St

3 28 1927 C. HAMPSON JONES, M. D. Registrar

Per Asst

tion should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should state CA... OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIO... very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19533

## CERTIFICATE OF DEATH

16-67 21

E 19533

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH (No.)

City of BALTIMORE: (No. ~~3323 Gwynns Falls Parkway~~ St. Ward

2-FULL NAME Mary C. Sinn.

(a) RESIDENCE NO. 3323 Gwynns Falls Parkway St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Late George P. Sinn

6 DATE OF BIRTH (month, day, and year) May 29, 1847

| 7 AGE Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|
| 79 | 8 9 | 27 | |

8 OCCUPATION OF DECEASED None

(a) Trade, profession or particular kind of work ....

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) New York

(State or country) N. Y.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) ....

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ....

(State or country) Unknown

14 Informant Mr Ralph B. Sinn.

(Address) 3323 Gwynns Falls Parkway

15 Filed ....19.... C. HAMPSON JONES, M. D.

Per ....Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Febuary 26, 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 20 19 27, to Feb. 26, 19 27

that I last saw h alive on Feb. 26, 19 27

and that death occurred, on the date stated above, at 11 45 P. m.

The CAUSE OF DEATH* was as follows:

Facial Erysipelas

(duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Cardiac Arrest

(duration) ....yrs. ....mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Stanley McElroy, M. D.

, 19 (Address) 1609 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — Date of Burial: March 1 1927

20 UNDERTAKER: Jos Joerdens + Son — ADDRESS: 217 S. Paca St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS specify state OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

MAR 2 1927

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19534

E 19534

## CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1212 Division ST. 17-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Gumby

(a) RESIDENCE NO. 1212 Division ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | col | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. Gumby

6 DATE OF BIRTH (month, day, and year) Jan 1 - 1891

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 36 | 1 | 26 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) maryland

PARENTS

10 NAME OF FATHER John Speaks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Hannie Hansen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Wm. Gumby (Address) 1212 Division St.

15 Filed MAR 28 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 27 1927

17

I HEREBY CERTIFY, That I attended deceased from Nov. 24, 1926, to Feb. 27, 1927, that I last saw h alive on Feb. 27, 1927, and that death occurred, on the date stated above, at 4:29 P. m.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency

(duration) yrs. 3 mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw. J. Mueller, M. D

Feb 28, 1927 (Address) 1230 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 3/2/ 1927

20 UNDERTAKER Mrs. Geo. H. Holland ADDRESS 1631 Druid Hill ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E. 19535

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E. 19535

## CERTIFICATE OF DEATH.

9 REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 1615 Madison Ave. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Nichols

(a) RESIDENCE NO. 1615 Madison Ave. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 29 '25

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 1 | 6 | 29 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md.

PARENTS

10 NAME OF FATHER Edgar Nichols

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Susan Franklin

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Edgar Nichols

(Address) 1615 Madison Ave

15 Filed 2/28 1927 CLAMPSON JONES, M. D. Registrar

By CRK

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 25, 1927, to Feb 28, 1927, that I last saw him alive on Feb 28, 1927, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

1 Broncho Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Whooping Cough (about 5 months previous)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. William Frey, M. D.

2/28, 1927 (Address) 1928 Ca. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem Date of Burial March 2 1927

20 UNDERTAKER Jos Geo. H Holland ADDRESS 163 Druid Hill ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSES OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 19536

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19636

## CERTIFICATE OF DEATH.

86-001

1-PLACE OF DEATH U.S Marine Hospital No 1. REGISTERED NO.

CITY OF BALTIMORE: (No. Balt. 2nd ST. 17-51 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard Ramsey.

(a) RESIDENCE NO. (on Steamship) Balt. Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male. | White | Unknown |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — unknown

6 DATE OF BIRTH (month, day, and year) 1906 — —

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 21 | — | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) Ocean

(c) Name of employer S/S Eleanor Christensen Ohio.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER David Ramsey.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant Self

(Address)

Filed 2 8 1927 C. HAMPSON JONES, M. D. Registrar

Par AR 11

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 27 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 21, 1927, to Feb. 27, 1927, that I last saw h— alive on Feb 27, 1927, and that death occurred, on the date stated above, at 5 15 P. m.

The CAUSE OF DEATH* was as follows:

Acute Toxic. Nephritis

Acute Nasobronchitis

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) Acute Pneumonitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? On board Ship.

Did an operation precede death? yes Date of 2-22-27

Was there an autopsy? not

What test confirmed diagnosis? Laboratory findings

(Signed) C. L. Whitworth, M. D.

, 19 (Address) U.S. Marine Hospital Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Barnesville, Ohio DATE OF BURIAL Feb 28, 1927

20 UNDERTAKER E. LeRoy Steffler ADDRESS 125 E. Monument

CAUSE OF DEATH must be plainly written. See instructions on back of certificates.

Spec.--12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19537

## CERTIFICATE OF DEATH.

31 E 19537

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St., 19-B Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lawrence Dix (Lawrence E. Sipes)

(a) RESIDENCE NO. 2613 Bernard st. St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1899

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 27 | 8 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) _____

(State or country) Maryland

PARENTS

10 NAME OF FATHER Harry Dix

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Florence Dix

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed HAMPSON JONES, M. D.

Registrar

28 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

February 28, 1927

17

I HEREBY CERTIFY, That I attended deceased from February 16 19 27, to February 28, 19 27, that I last saw him alive on February 28, 19 27, and that death occurred, on the date stated above, at 7.30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
Tuberculous Laryngitis
2-16-27 to 2-28-27 (duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) _____

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. E. Gabbett, M. D.

2-28-27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary's Hampstead. Date of Burial 3/2/ 1927

20 UNDERTAKER Hallett Davis ADDRESS 2307 Eutaw St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

# E 19538 HEALTH DEPARTMENT—CITY OF BALTIMORE E 19538

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 819 E. 34th st (St.) 13-52 (Ward) REGISTERED NO. 159-E3

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlotte May Shipley

(a) RESIDENCE No. 819 E 34th st St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? 0 yrs. 0 mos. 18 ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Infant

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb. 9/1927.

7 AGE

| Years | Months | Days | If LESS than 1 day, hrs. or ..... min. |
|---|---|---|---|
| 0 | 0 | 18 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore city Md.

PARENTS

10 NAME OF FATHER: Charles T. Shipley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto city Md.

12 MAIDEN NAME OF MOTHER: Mary E. Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto city Md.

14 Informant: Charles T. Shipley (Address) 819 E. 34th st

15 2 8 1927 C. HAMPSON JONES, M. D. Registrar Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 27 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 9th, 1927, to Feb 27th, 1927, that I last saw h— alive on Feb 26th, 1927, and that death occurred, on the date stated above, at 5.15 P m.

The CAUSE OF DEATH* was as follows:

Spinal Bifida (Bent Deformity)

(duration) yrs. mos 18 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jos. M. Dorsey M. D.

2/27, 1927 (Address) 84 W 36th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery Md. DATE OF BURIAL 3/1 1927.

20 UNDERTAKER: J. Walter Davis ADDRESS 3307 Paine St

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

(Haire)

E 19539

HEALTH DEPARTMENT—CITY OF BALTIMORE

45 E 19539

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospitals 18-76 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alva Haire

(a) RESIDENCE NO. 879 W Fayette St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Daisy Haire

6 DATE OF BIRTH (month, day, and year): June 1877.

7 AGE: Years 50 | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machinist

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Ohio

(State or country)

PARENTS

10 NAME OF FATHER South Haire

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Illinois

12 MAIDEN NAME OF MOTHER Jennie Fountain

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ohio

14 Informant: Daisy Haire

(Address) 879 W Fayette St

15 C. HAMPSON JONES, M. D. Registrar

2 8 1927 Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 26 1927

17

I HEREBY CERTIFY, That I attended deceased from 9-7- 1926 to 2-26 1927.

that I last saw him alive on 2-26 1927

and that death occurred, on the date stated above, at 5:00 a. m.

The CAUSE OF DEATH* was as follows: Carcinoma of Rectum

(duration) subacute yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 4-15-26

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) H. Meyer, M. D.

, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Balto. Cem. Date of Burial 3/1, 1927

20 UNDERTAKER: Fredk. A. Cole ADDRESS 1411 Hollins St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19540

## CERTIFICATE OF DEATH.

100-001

E 19540

1-PLACE OF DEATH

City of BALTIMORE: (No. 1823 Orleans St St. 6-9 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annabelle Bordley

(a) RESIDENCE NO. 1823 Orleans St St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | col | single |

3a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXX

6 DATE OF BIRTH (month, day, and year) Jan 20/26

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 1 | 1 | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Ernst Bailey

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary Bordley

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto., Md.

14 Informant Mary Bordley (mother)

(Address) 1823 Orleans St

15 Filed_____, 19____ _____ Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 Feb 26/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Bronchopneumonia (Primary,

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) _____, M. D.

(Coroner)

2/28/27 18 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury cemetery Date of Burial Mar 1 1927

20 UNDERTAKER Edward Bryan ADDRESS 1681 orleans st

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAR 1 1927 C. HARRISON KYLE M.D.

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 19541 ✓ 101-001 E 19541

1-PLACE OF DEATH

REGISTERED NO. 12-51

City of BALTIMORE: (No. Provident Hospital St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Vaughn

(a) RESIDENCE NO. 105 W. 20th St. Ward 9a

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colord

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1892

7 AGE: Years 35 Months — Days — IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Va

(State or country)

PARENTS

10 NAME OF FATHER: Samuel Stiff

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Va

12 MAIDEN NAME OF MOTHER: Kitt Saxon

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Unknown

14 Informant: Thomas Stiff

(Address) 105 W 20th St.

15 Filed MAR 1 - 1927 R. HAMPTON JONES, M. D. Registrar.

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/25/27

17 I HEREBY CERTIFY, That I attended deceased from 2/24, 1927, to 2/25, 1927, that I last saw her alive on 2/25, 1927, and that death occurred, on the date stated above, at 4:45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Dysentery

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) Edward D. Gaines, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Prospects Va

Date of Burial: March 4 1927

20 UNDERTAKER: Daniel Carlos

ADDRESS 5164 Pine

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 19542 — REGISTERED NO. E 19542

1-PLACE OF DEATH

City of BALTIMORE: (No. 1021 argyle ave St. 17-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Woodland

(a) RESIDENCE NO. 1021 argyle ave St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colord | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1880

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 47 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Mary's Co Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Burtunda Jarred

(Address) 1414 Mountain Ave

15 Filed MAR 1 1924 C. HAMPTON JONES, M. D. Registrar

Per K K

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/24 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest

(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Arterial Sclerosis

Cardiac Dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Raul Green M. D.

(Coroner)

, 19 (Address) 3320 Reed

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dr A Odenheimer Date of Burial March 4 1924

20 UNDERTAKER Edward Eastern ADDRESS 54 and

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH E 19543 — Shelter for Aged Colored — REGISTERED NO. 74 E 19543

CITY OF BALTIMORE: (No. 517 W. Biddle ST. — WARD 17)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lavina Anderson

(a) RESIDENCE NO. 517 W. Biddle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Colored | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1839

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 88 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ...

(b) General nature of Industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Mahala Smith 519 W. Biddle St.
(Address)

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 28 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 27, 1927, to Feb 27, 1927, that I last saw her alive on Feb 27, 1927, and that death occurred, on the date stated above, at 12:30 A m

The CAUSE OF DEATH* was as follows:

Cerebral, Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Senility & Arteriosclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) [illegible], M. D.

, 19 (Address) 1335 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem. — DATE OF BURIAL Mch 1 1927

UNDERTAKER Chas. E. Brack Sr. — ADDRESS Madison

Filed MAR 1 - 1927 HAMILTON JONES, M. D. Registrar

Per RH

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19544 — E 19544

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital — Registered No. 146

City of BALTIMORE: (No. Lombard & Green St. 15-21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Jones

(a) Residence No. 1531 Woodyear St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced. (Write the word.) married

5a-If married, widowed, or divorced [redacted] of (or) WIFE of John H Jones

6-DATE OF BIRTH (month, day and year) Jan 27, 1891

7-AGE. 36 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country). Barnesquarter Md

PARENTS:

10-NAME OF FATHER. Noah W. Jones.

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Eastern Shore Md.

12-MAIDEN NAME OF MOTHER. Martha E. Jones

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Eastern Shore Md

14-

(Informant) John H. Jones

(Address) 1531 Woodyear St.

15-

Filed 1927 192 [illegible] Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 2-27-27

17- I HEREBY CERTIFY, That I attended deceased from 2-14 1927 to 2-27 1927

that I last saw h[redacted] alive on 2-27 1927

and that death occurred, on the date stated above, at 1[illegible] A. M.

The CAUSE OF DEATH* was as follows:

Generalized peritonitis
Ruptured Secondary
Abdominal pregnancy

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Bronchial pneumonia

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 2 26 27

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical diagnosis Microscopic

(Signed) [illegible] M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Deals Island Eastern Shore Md.

DATE OF BURIAL. March 1 1927

20-UNDERTAKER. Mrs Jas H. Dennis per T. E. Nelson

ADDRESS 1303 Pressman st

instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 19545

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

14-001

REGISTERED NO. E 19545

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1376 W. Carey ST. 15-23 WARD)

2-FULL NAME Mary Rebecca Ruff

(a) RESIDENCE NO. 1376 W. Carey ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Chas. J. Ruff.

6 DATE OF BIRTH (month, day, and year): Aug 7, 1884

7 AGE

| Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|
| 42 | 6 | 20 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Lottie Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Cordelia Harris

(Address) 1376 W. Carey St.

Filed MAR 1 1927, 19 C. HAMPSON JONES, M. D. Registrar

By RK

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 27 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1927, to Feb 27, 1927,

that I last saw h~~e~~ alive on Feb 26, 1927

and that death occurred, on the date stated above, at 12:20 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos 17 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Wm. H. Wright, M. D.

Feb 28, 1927 (Address) 1209 Perkinsman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Osborn Evergreen Cem

DATE OF BURIAL: March 2 1927

20 UNDERTAKER: Wm. J. G. Locks

ADDRESS: 1302 Jeffer

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 19546

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 19546

## CERTIFICATE OF DEATH.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home & Infirmary St. 6-9 Ward)

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Rachel Sherr

(a) RESIDENCE NO. 29 N. Ann St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? 29 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: w

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Alex Sherr

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE: Years 52 | Months — | Days — | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country) Russia

PARENTS

10 NAME OF FATHER Jack Arsh

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Russia

12 MAIDEN NAME OF MOTHER Fenton

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Russia

14 Informant Jack Lewis

(Address) 1439 Eutaw St

15 Filed ..... 19 .....

Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

February 28, 1927

17

I HEREBY CERTIFY, That I attended deceased from February 24 1927, to February 28, 1927, that I last saw her alive on February 28, 1927, and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) ..... yrs. ..... mos. 2 hours ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Vernon K. Nonwood, M. D.

Feb 28 1927 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mehrer Rosedale — Date of Burial: 3/1/27

20 UNDERTAKER: Jack Lewis — ADDRESS: 1439 Eutaw

MAR 1 - 1927

HAMILTON JONES, M. D.

Spec.-7-17-26—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 19547

REGISTERED NO. E 19547

1-PLACE OF DEATH

City of BALTIMORE: (No. Univ Hospital St. 4-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Read (Miss)

(a) RESIDENCE NO. Westminster Md Ward R.F.D #5

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| fem | W | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..hrs. or ..min.. |
|---|---|---|---|---|
| | 80 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General natore of indostry, hosiness, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (City or town)
(State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Not Known

14 Informant M T Reese
(Address) Westminster Md.

15 Filed MAR 1 - 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/28 1927

17 I HEREBY CERTIFY, That I attended deceased from 2/27, 1927, to 2/28, 1927,

that I last saw her alive on 2/28, 1927,

and that death occurred, on the date stated above, at 4:10 P m.

The CAUSE OF DEATH* was as follows:

Strangulated Femoral Hernia with Intestines, Obstruction

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Tobacco from Cystitis Fecal Obstruction

Pulmonary Edema (duration) yrs. mos. 1 da.

18 Where was disease contracted

If not at place of death? Westminster Md.

Did an operation precede death? Yes Date of 2/27/27

Was there an autopsy?

What test confirmed diagnosis? Herniotomy

(Signed) [illegible] M. D.

, 19 (Address) Univ Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Westminster Md | Mar 3 1927 |
| 20 UNDERTAKER W M Routson | ADDRESS 22 S N Main |

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

E 19548

# HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001

E 19548

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. St Agnes Hospital St. 20-7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Calder Finnegan

(a) RESIDENCE NO. 15 Paloma Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1/2 yrs. mos. da. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. da.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 28, 1927

7 AGE Years Months Days IF LESS than 1 day, hrs. or min.: (3 hours)

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Harry J Calder

11 BIRTHPLACE OF FATHER (City or town)

(State or country) ~~Md~~ not given Md

12 MAIDEN NAME OF MOTHER Doris E Seybold

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Harry J Calder

(Address) 15 Paloma Ave

15 Filed ..... 19..... By ..... Registrar

C. HAMILTON JONES, M. D.

APR - 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-28 1927

17 I HEREBY CERTIFY, That I attended deceased from 2-28, 1927, to 2-28, 1927, that I last saw h alive on 2-28, 1927, and that death occurred, on the date stated above, at 1 30 p m.

The CAUSE OF DEATH* was as follows:

PREMATURITY

3 hrs.

(duration) yrs. mos da.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos da.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem

Date of Burial 19 27

20 UNDERTAKER: H M Cole

ADDRESS 502 E Mulb

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Dr Blake—1014 East Lafayette Ave

Spec.—7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 19549

129 E 19549

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1734 Bolton St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Jacob Kahler

(a) RESIDENCE NO. 1734 Bolton St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Matilda Kahler

6 DATE OF BIRTH (month, day, and year) June 10, 1847

| 7 AGE | Years | Months | Days | IF LESS than 1 day ... hrs. or ... min. |
|---|---|---|---|---|
| | 80 | 7 | 16 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Commission

(c) Name of employer Self

9 BIRTHPLACE (city or town) Bath Md

(State or country)

PARENTS

10 NAME OF FATHER Jacob Kahler

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine Kind

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Matilda Kahler

(Address) 1734 Bolton St

15 Filed ..., 19... HAMPSON JONES, M. D.

Per ... Registrar

MAR 7 - 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 21 1927

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1926 to Feb. 26 1927

that I last saw him alive on Feb. 26 1927

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation old age.

(duration) ... yrs. 1 mos. ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No Physical

What test confirmed diagnosis?

(Signed) Hubert C Blake, M. D.

2-28 1927. (Address) 1014 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge — Date of Burial: Mar 1927

20 UNDERTAKER: H. A. Cook — ADDRESS: 503 Eutaw St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

Dr Thomas - Clinton Clymont

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 19550

REGISTERED NO. E 19550

1-PLACE OF DEATH

City of BALTIMORE: (No. 4814 Park Heights Ave St. 27-56 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena King

(a) RESIDENCE NO. 4814 Park Heights Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo King

6 DATE OF BIRTH (month, day, and year): Oct 19, 1855

7 AGE: Years 71 Months 4 Days 8 IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: John Hemitz

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Geo W. King

(Address) 4814 Park Heights Ave

15 Filed MAR 1 - 1927 C. HAMPSON JONES, M.D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 19 27

17 I HEREBY CERTIFY, That I attended deceased from 1-20- 27, to 2-27 27.

that I last saw h alive on 1-20- 27.

and that death occurred, on the date stated above, at 1.30 m.

The CAUSE OF DEATH* was as follows: Pneumonia

(duration) — yrs. 7 mos — ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 1 yrs. — mos — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Latimer, M. D.

, 19 (Address) 320 E Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Date of Burial March 1 19 27

20 UNDERTAKER: H. C. Cook ADDRESS 1312 Eutaw

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19551 E 19551

## CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1808 Rutland Ave ST. 8-17 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexius Josephus Meyers

(a) RESIDENCE NO. 1808 Rutland Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 14 1858

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 68 69 | 6 | 13 14 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Alexius J. Meyers Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary A Stansbury

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Harry A. Geary
(Address) 1808 Rutland Ave

15 Filed MAR 1 1927 Fee J. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 27th 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb-1 1927 to Feb-27- 1927.
that I last saw him alive on Feb-27- 1927.
and that death occurred, on the date stated above, at 10 A.M. P. m.

The CAUSE OF DEATH* was as follows:

Acute Dilation of right Ventricle

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Intestinal Nephritis

Arterio Sclerosis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Samuel A Kaufman, M. D.

, 19 (Address) 937 Meadow Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL 3/2 19 27

20 UNDERTAKER Wm Cook — ADDRESS 502 E 10th

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 19552

REGISTERED NO. 1929 E 19552

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 852 Ramsey ST. 21-29 WARD)

2-FULL NAME Harriet Spain

(a) RESIDENCE NO. 852 Ramsey ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fem Mulr

4 COLOR OR RACE

5 ~~Single~~, Married, ~~Widowed~~, or Divorced, ~~(write the~~ word) Marrd

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Spain

6 DATE OF BIRTH (month, day, and year) 1856

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs or ....min. |
|---|---|---|---|---|
| 70 | 71 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Don't know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs Spain

(Address) 852 Ramsey

15 Filed MAR 1 - 1929 19 C. HAMPSON JONES, M. D. Registrar

For

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-28 1929

17 I HEREBY CERTIFY, That I attended deceased from January 1, 1929, to Feb 28, 1929, that I last saw h[illegible] alive on 2-28-1929, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 6 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Rupert Blue, M. D.

, 19 (Address) Surg Gen U S Pub Hlth Serv

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westpoint, King William Co Va

DATE OF BURIAL Mar 2 1929

20 UNDERTAKER W H Cook

ADDRESS 502 E Nash St

CAUSE OF DEATH to be filled in plain terms, so that it may be properly classified. See instructions on back of certificate. IMPORTANT. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

Liberty

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19553

## CERTIFICATE OF DEATH

129 E 19553

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3127 E Baltimore St. 20-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis A Dentz

(a) RESIDENCE NO. 3128 Stafford St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): July 28-1865

7 AGE: Years 61 Months 6 Days 29 IF LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Butcher

(b) General nature of industry, business, or establishment in which employed (or employer): Grocerie

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER: Louis Dentz

11 BIRTHPLACE OF FATHER (City or town): Germany

(State or country)

12 MAIDEN NAME OF MOTHER: Mrs C. Bruch

13 BIRTHPLACE OF MOTHER (city or town): Baltimore

(State or country)

14 Informant: Henry A. Dentz

(Address): 3128 Stafford St

Filed MAR 1 - 1927 H. HOUSTON JONES, M. D. Registrar

By ____

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 27 19 27

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 19 27 to Feb 27, 19 27.

that I last saw h[illegible] alive on Feb 10, 19 27.

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia. Chr

Interstitial Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY Arteriosclerosis

(Secondary)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Hosp. Records

(Signed) Armada Mrs Becker M. D.

, 19 (Address) 401 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cem.

Date of Burial: Mar. 1 19 27

20 UNDERTAKER: Chas. W. Dill.

ADDRESS 3109 Fredk, Ave.

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

19554

38E 19554

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1002 Vine St. 18-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Brown

(a) RESIDENCE NO. 1002 Vine St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | Col | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lizzie Brown

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|---|
| | 52 | — | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) General

(c) Name of employer —

9 BIRTHPLACE (city or town) Va.
(State or country)

PARENTS

10 NAME OF FATHER Nickolas Brown

11 BIRTHPLACE OF FATHER (City or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Lizzie Brown
(Address) 1002 Vine St

15 Filed MAR 1 1927 19 C. HAMPSON JONES, M. D. Registrar

Per R.H.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/26/1927

17 I HEREBY CERTIFY, That I attended deceased from 2/20/1927, to 2/26/1927, that I last saw h[illegible] alive on 2/26/1927, and that death occurred, on the date stated above, at 5:00 A.m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

About 6 (duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (probably Luetic)

About 6 (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

2/28/1927 (Address) 908 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dispatch, Va. Date of Burial Mar. 2, 1927

20 UNDERTAKER Mrs Kate R. Williams ADDRESS [illegible] N. Schroeder

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19555

## CERTIFICATE OF DEATH.

+188-002

E 19555

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. Gen. Hosp. St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME ~~Mrs.~~ Nettie M. Mann

(a) RESIDENCE NO. Mt. Wilson Lane St. 1. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 23. 1909

7 AGE: Years 17 Months 6 Days 4 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer) U. S. F. & G.

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Fosterman W. Va

PARENTS

10 NAME OF FATHER Orville R. Mann

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Monroe Co. W. Va.

12 MAIDEN NAME OF MOTHER Elizabeth Alderman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Farmville Va.

14 Informant Orville R. Mann

(Address) Mt. Wilson Md.

15 Filed Feb. 28 1927 C. HAMILTON JONES, M. D. Registrar

Per R. M.

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 27, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Fracture of skull (accidental) Struck by accident

(duration) 17 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D. (Coroner)

Feb. 28, 1927 (Address) 2502 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery Date of Burial Mar 1 1927

20 UNDERTAKER: Frank H. Newell ADDRESS Pikesville Md

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19556

## CERTIFICATE OF DEATH.

26-42 179

REGISTERED NO. E 19556

1-PLACE OF DEATH:

City of BALTIMORE: (No. St. Joseph Hospital St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Elizabeth Slinbach

(a) RESIDENCE NO. 25 Quick Ave Raspberg St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | white | dingle |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXXX

6 DATE OF BIRTH (month, day, and year) Aug 30/1925

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 1 | 5 | 28 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Bernard Slinbach

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Marie Muller

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto., Md.

14 Informant Bernard Slinbach

(Address) 25 Quick Ave

15 Filed C. HAMILTON JONES, M. D. Registrar

1927 Per R.C.

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27/ 192 e.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Burns over neck &body.. Clothed caught fire while she was playing with matches feb 26/27

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. E. Miller M. D. (Coroner)

19 2/28/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery Date of Burial 3/1 1927

20 UNDERTAKER Chas. F. Kane & Son ADDRESS 1811 W. Royal Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19557

1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

4-30

E 19557

REGISTERED NO.

City of BALTIMORE: (No. University Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Hall

(a) RESIDENCE NO. Queenstown A. A. Co. Md. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 24, 1904

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 22 | 6 | 2 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Edward Hall

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Ella Harig

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Asa Hall (Brother)

(Address) Queenstown A. A. Co. Md.

15 Filed MAR 1 - 1927 19 Registrar Glenburnie

C. HAMILTON JONES, M. D.

Per

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 25, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonalis

(duration) yrs, mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) (Coroner) M. D.

2/28 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Furnace Branch Date of Burial Mar 1 1927

20 UNDERTAKER a a co md ADDRESS

John F Denny 715 [illegible] St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. -7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

19558 — 4-25-27 — E 19558

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 627 West Redwood St. 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary J. Robertson

(a) RESIDENCE NO. 627 West Redwood St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. mos. da. How long in U. S. if of foreign birth? yrs. mos. da.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Female | White | Widowed |

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: Mr. Robertson

6 DATE OF BIRTH (month, day, and year): April 23, 1862

7 AGE

| Years | Months | Days | IF LESS than 1 day ... hrs. or ... min.. |
|---|---|---|---|
| 64 | 10 | 5 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country) Virginia

PARENTS

10 NAME OF FATHER: William Robinson

11 BIRTHPLACE OF FATHER (City or town):

(State or country) Calverty County, Md.

12 MAIDEN NAME OF MOTHER: Priscilla Robinson

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Calvert County, Md.

14 Informant: Jesse Robinson

(Address) 627 West Redwood Street

15 Filed ... 19 ... C. HAMPSON JONES, M. D. Registrar

4-25-1927 Per ...

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: February 28, 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 10th, 1926, to Feb 28th, 1927, that I last saw h. alive on Feb 28, 1927, and that death occurred, on the date stated above, at 8.30 A.m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(duration) 2 yrs. mos. da.

CONTRIBUTORY (Secondary) Unknown.

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Personal observation

(Signed) Maynard Ladd, M. D.

2-28 19 27 (Address) 1900 Maryland Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — Date of Burial: Mar. 1 1927

20 UNDERTAKER: Joseph B Cook — ADDRESS 1003 W Baltimore

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

Leitenberger

E 19559

# HEALTH DEPARTMENT—CITY OF BALTIMORE

122-001

E 19559

## CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospital Ward 21-29)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Leitenberger

(a) RESIDENCE NO. 1114 Cooper St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| M | W | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1877

| 7 AGE Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|
| 50 | xxx | xxx | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cainter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Pa

(State or country)

PARENTS

10 NAME OF FATHER John Leitenberger

11 BIRTHPLACE OF FATHER (city or town) Pa

(State or country)

12 MAIDEN NAME OF MOTHER Carolyn Unknown

13 BIRTHPLACE OF MOTHER (city or town) Pa

(State or country)

14 Informant City Hospital Records

(Address) Eastern Avenue

15 Filed 19 HARRISON JONES, M. D. Registrar

R 1 - 1927 Par 21

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 Feb. 27.

17 I HEREBY CERTIFY, That I attended deceased from Feb. 17. 1927 to Feb. 27. 1927 that I last saw h alive on Feb 27. 1927 and that death occurred, on the date stated above, at 10.30 P.M.

The CAUSE OF DEATH* was as follows: Atrophic Cirrhosis of Liver

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Lemmus Bronchopneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of Feb 25. 1927

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) W Blair Creed, M. D.

2-28. 1927 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mahanoy City Pa Date of Burial Mar 1st 1927

20 UNDERTAKER Joseph Cook ADDRESS 1003 N Eutaw St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

19560

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

10-1 E 19560

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Franklin Sq. Hospital

CITY OF BALTIMORE: (No. Fayette & Calhoun Sts.) (WARD) 14-35

2-FULL NAME Katherine Schoenfelt.

(a) RESIDENCE NO. 1407 Fawnman St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 15, 1925

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 2 | 0 | 13 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER Peter Schoenfelt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margit Gerling

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. M. Schoenfelt

(Address) 1407 Fawnman St.

15 Filed APR 1 1927 19 Per R. J. C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 28 1927

17

I HEREBY CERTIFY, That I attended deceased from 2/25/27, 19 , to 2/28/27, 19 ,

that I last saw h[illegible] alive on 2/28/27, 19 ,

and that death occurred, on the date stated above, at 3-30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

2/25/27 to 2/28/27 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilitation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical Signs

(Signed) [illegible] M. D.

, 19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem.

DATE OF BURIAL Mar. 1 1927

20 UNDERTAKER Margaret J. Flynn

ADDRESS 1417 Light St

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 19561

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 19561

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1231 Argyle Ave ST., 17 24 WARD)

2-FULL NAME Jennie Steele

(a) RESIDENCE NO. 1231 Argyle Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40~~6~~ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Colored | Married |

5a If married, widowed, or divorced (or) WIFE of Wm. Steele

6 DATE OF BIRTH (month, day, and year) Unknown 1877

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or ..... min. |
|---|---|---|---|---|
| | approx 60 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va (State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Wm Steele Husband (Address) 1231 Argyle Ave

15 Filed MAR 1 1927 Per

C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 1926 to Feb 26 1927.

that I last saw her alive on Feb 26 1927,

and that death occurred, on the date stated above, at 7.30 P.m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Paren Chymatous Nephritis and hypertension (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) R J [illegible] M. D.

2/28 1927 (Address) 1429 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL 3/1 1927

20 UNDERTAKER Samuel Wemsley ADDRESS 37 N Eden

TION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 19562 45 E 19562

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 9 N. Calhoun St., 19-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Rodolph Warfield

(a) RESIDENCE NO. 9 N. Calhoun St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary C. Warfield

6 DATE OF BIRTH (month, day, and year): June 23 1848

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..hrs. or ..min.. |
|---|---|---|---|---|
| | 78 | 8 | 27 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Anne Arundel Co

PARENTS

10 NAME OF FATHER: Allen Warfield

11 BIRTHPLACE OF FATHER (City or town) (State or country): Anne Arundel Co

12 MAIDEN NAME OF MOTHER: Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Mrs Mary C. Warfield

(Address): 9 N. Calhoun St.

15 Filed MAR 1 - 1927 Per

16 C. HAMPSON JONES M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 27 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 11 1927 to Feb. 27 1927

that I last saw him alive on Feb. 27 1927

and that death occurred, on the date stated above, at 6 35 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Intestines

Possible history of (duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical symptoms.

(Signed) A. F. Robinson, M. D.

2/28 1927 (Address) 836 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Loudon Park | March 2 1927 |

20 UNDERTAKER: George J. Smith — ADDRESS 1532 Hallins

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

(Owens. Marshall)

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 19563

E 19563

## CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 859 W Lexington St. 16-26 Ward)

2-FULL NAME Owens marshall

(a) RESIDENCE NO. 859 W Lexington St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | Col | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jane Marshall

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 35 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer C W Shafer

9 BIRTHPLACE (city or town) Balt

(State or country) md

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Byron Wright

(Address) 1218 Mt Elderry St

15 Filed ..... 19 C. HAMILTON JONES, M. D. Registrar

APR 1 - 1927 Per RH

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Cardiac Dilatation

Contributory Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Leonard J. Wisner M. D.
(Coroner)

19 27 (Address) 3328 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

Date of Burial 3/2 19 27

20 UNDERTAKER D. Frow Wright

ADDRESS 1218 Mt Elderry St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19564

## CERTIFICATE OF DEATH.

90 E 19564
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1205 N. Washington ST. 8-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George A. Adams

(a) RESIDENCE NO. 2127 E. Federal ST. ... WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.
(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year) April 10 - 1889

7 AGE

| Years | Months | Days | If LESS than 1 day, hrs or min |
|---|---|---|---|
| 37 | 10 | 17 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Driver

(b) General nature of industry, business, or establishment in which employed (or employer): American Ice Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: George E. Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Lilly White

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: George A. Adams
(Address): 2127 E Federal St

15 Filed ... 19 ... Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 8, 1927, to Feb 27, 1927,

that I last saw h[illegible] alive on Feb 27, 1927

and that death occurred, on the date stated above, at 9:30 a. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Chronic nephritis 2 years

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John W Davidson, M. D.

, 19 (Address) 1414 N Carrey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: 3/2 1927

20 UNDERTAKER: Albert L Hiltz Jr — ADDRESS: 1606 N Chester St

FILED MAR 1 - 1927 C. HAMPSON JONES, M. D.

IMPORTANT—See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19565

## CERTIFICATE OF DEATH.

90 E 19565

1-PLACE OF DEATH Emmasly Hospital

City of BALTIMORE: (No. Joseph H. Fuller St., 9-99 Ward)

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Fuller

(a) RESIDENCE NO. 2 [illegible] St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 Color or Race W

5 ~~Single~~, ~~Married~~, Widowed, or Divorced, (write the word) Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 24 1892

7 AGE Years 35 Months 1 Days 2 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work [illegible]

(b) General nature of industry, business, or establishment in which employed (or employer) Shipping Clerk

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto

PARENTS

10 NAME OF FATHER Henry A. Miller

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto.

12 MAIDEN NAME OF MOTHER Elizabeth Hicks

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto

14 Informant Elizabeth Miller

(Address)

15 [illegible] 1927

16 THOMPSON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-26-27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Thomas A. Jones M. D.
(Coroner)

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Country Date of Burial Mar 2 1927

20 UNDERTAKER F. A. Glauner & Son ADDRESS 703 Hamilton Ave.

Cor.—12-9-25—A Co.—200 Bks. ... Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 19566

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

74-96 h.

E 19566

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1708 Mulliken ST., 69 (WARD)

2-FULL NAME Mary E. Edwards

(a) RESIDENCE NO. 1708 Mulliken ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Edwards.

6 DATE OF BIRTH (month, day, and year): Sept 7-1864

7 AGE: Years 62 | Months 5 | Days 18 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Co. Md

PARENTS

10 NAME OF FATHER: Maoack Hill

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Co Md

12 MAIDEN NAME OF MOTHER: Anna Chase

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Co Md

14 Informant: John Edwards
(Address): 1708 Mulliken St

15 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 26 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 17 1927, to Feb 26 1927, that I last saw h alive on Feb 25 1927 and that death occurred, on the date stated above, at 3 A.M. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) 6 yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Paralysis.

(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? x

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physician

(Signed) F. C. Smith, M. D.

Feb 26 1927 (Address) North Ave & Division

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Cem. | DATE OF BURIAL: 3/1/27

20 UNDERTAKER: Wm. R. G. Elliott | ADDRESS: 1125 Ashland Ave

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19567

100-001

E 19567

## CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 933 Mc Donough St

CITY OF BALTIMORE: (No. ..... ST., 7-13 WARD)

2-FULL NAME Wash Allen

(a) RESIDENCE NO. 933 Mc Donough ST., ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lenman

6 DATE OF BIRTH (month, day, and year): Lenman 1885

7 AGE: Years 42; Months; Days; If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): S. C.

PARENTS

10 NAME OF FATHER: Wash Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country): S. C.

12 MAIDEN NAME OF MOTHER: Lenman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Lenman

14 Informant: Matilda Allen

(Address) 933 Mc Donough St

15 Filed 1927, 19 C. HAMPSON JONES, M. D. Registrar

Per .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2-25 1927

17 I HEREBY CERTIFY, That I attended deceased from 2-22-27, 19 ..., to 2-25-, 19 27.

that I last saw h— alive on 2-25-, 19 27.

and that death occurred, on the date stated above, at 12:20 P. m.

The CAUSE OF DEATH* was as follows:

Terminal Pneumonia

Pulmonary Edema

Mitral Insufficiency (Organic)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. B. Butler, M. D.

, 19 (Address) 425 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount S. C.

DATE OF BURIAL: 2/1/27

20 UNDERTAKER: Mrs. R. G. Elliott

ADDRESS 715 Ashland

ATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 19568

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19568

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. 33rd Calvert St. Ward)

REGISTERED NO. 96-42 100-00

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Willie Elizabeth Boyd

(a) RESIDENCE NO. 17 Rockdale Ave St. Raspeburg WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb. 15-1927

7 AGE: Years | Months | Days: 16 17 | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Fred C. Boyd

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Susan Lowe

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: Frederick C. Boyd

(Address) 17 Rockdale Ave Raspeburg

15 Filed - 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 1st 1927

17

I HEREBY CERTIFY, That I attended deceased from 2-15, 1927, to 3-1, 1927,

that I last saw h alive on 2-28, 1927,

and that death occurred, on the date stated above, at 1:30 m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary): bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Frank R. Smith, Jr., M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery — DATE OF BURIAL: March 2 1927

20 UNDERTAKER: Frederick Lassahn Sons — ADDRESS: Rideston

FOR IS very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Blks.

E 19569

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19569

## CERTIFICATE OF DEATH.

54

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St. 5-8 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roberta Trinholm

(a) RESIDENCE NO. 442 Somerset St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | Negro | Widowed |

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1900

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 27 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Kentucky

PARENTS

10 NAME OF FATHER Thomas Butler

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ky.

12 MAIDEN NAME OF MOTHER Alice —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ky

14 Informant

(Address) Records

15 Filed C. HAMPSON JONES, M. D. Registrar

1927 Per 1088

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 27 1927

17

I HEREBY CERTIFY, That I attended deceased from February 12 1927, to February 27, 1927, that I last saw alive on February 26, 1927, and that death occurred, on the date stated above, at 2:40 P. m.

The CAUSE OF DEATH* was as follows:

Generalized Vincents

Pellagra

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Laboratory

(Signed) R Hooper Smith, M. D.

March 19 27 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

BALTIMORE CITY HOSPITALS

JOHNS HOPKINS HOSPITAL MAR 1 1927

Commissioner Health.

Of the parties, as may be required by the Board of Health. Full statement of occupation is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19570

## CERTIFICATE OF DEATH.

129 E 19570

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St. 23-31 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Johnson

(a) RESIDENCE NO. 1012 Olive St St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | Negro | Widowed |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1855

| 7 AGE. | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 71 | | | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Maryland

PARENTS

10 NAME OF FATHER Arnold Taylor

11 BIRTHPLACE OF FATHER (city or town)
(State or country) md.

12 MAIDEN NAME OF MOTHER Lizzie Green

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant
(Address) BALTIMORE CITY HOSPITALS

15 Filed 1927 C. HAMPSON JONES, M. D.
Per 1089 Registrar

### MEDICAL CEHTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 25 1927

17
I HEREBY CERTIFY, That I attended deceased from February 12 1927, to February 25, 1927, that I last saw h[illegible] alive on February 25, 1927, and that death occurred, on the date stated above, at 7P m.

The CAUSE OF DEATH* was as follows:

Senility,
Chronic Interstitial Nephritis
Chronic Myocarditis & Mitral Disease
(duration) ? yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Myocardial Failure
(duration) yrs. mos. 2 ds.

18 Where was disease contracted
If not at place of death
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical & Laboratory
(Signed) C. Hampson Jones M. D.
Feb 28 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 19

20 UNDERTAKER ADDRESS

BALTIMORE CITY HOSPITALS
JOHNS HOPKINS HOSPITAL MAR 1 1927
Commissioner Health.

very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19571 100-001. E 19571

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [illegible] W. 70 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Jones

(a) RESIDENCE NO. 1727 Maryland Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Negro | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1895

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 32 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Va.

PARENTS

10 NAME OF FATHER Tuldo Jones

11 BIRTHPLACE OF FATHER (city or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER Henrietta —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant (Address) Records

15 [illegible] 1927 C. HANSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 27 1927

17

I HEREBY CERTIFY, That I attended deceased from February 24, 1927, to February 27, 1927.

that I last saw him alive on February 26, 1927,

and that death occurred, on the date stated above, at 1:30 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Gross & laboratory

(Signed) R. Hooper Smith, M. D.

March 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 19

20 UNDERTAKER ADDRESS

Very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 lots

E 19572

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19572

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 18-26 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daisy Black

(a) RESIDENCE No. 1126 Sarah Ann ST. City WARD
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 15 1926

7 AGE — Years: — Months: 7 Days: 11 If LESS than 1 day, hrs or min:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md —

PARENTS

10 NAME OF FATHER John Black

11 BIRTHPLACE OF FATHER (city or town) (State or country): S Car.

12 MAIDEN NAME OF MOTHER Goatelly Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va —

14 Informant Reeds.
(Address) JOHNS HOPKINS HOSPITAL

15 Filed JAN 1 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 21 1927 to Feb 26 1927

that I last saw her alive on Feb 26 1927

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Primary Lobar

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary): Pericarditis, Purulent

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? 1126 W. Sarah Ann St.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) H. E. Handley, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: 19 1927

20 UNDERTAKER: Commissioner Health.
Per. Wm. E. WOODALL

ADDRESS

MAR 2

TION is very important See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 19573

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

111-004

E 19573

1-PLACE OF DEATH Mercy Hospital

City of BALTIMORE: (No. Calvert and Saratoga St.) 13-59 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Hawkins

(a) RESIDENCE NO. 2112 Brookfield Ave St. Catonsville

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Miriam M. (nee Wilson)

6 DATE OF BIRTH (month, day, and year): Dec. 17. 1899.

7 AGE — Years: 27 | Months: 2 | Days: 10 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Advertising

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Calvert Co.

(State or country): Md.

PARENTS

10 NAME OF FATHER: John Edward Hawkins

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Calvert Co. Md

12 MAIDEN NAME OF MOTHER: Mary B. Slaughter

13 BIRTHPLACE OF MOTHER (city or town): Hunting

(State or country): Md.

14 Informant: John Hawkins

(Address): 636 North Bond St

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 27 19 27

17 I HEREBY CERTIFY, That I attended deceased from Feb. 26 1927, to Feb 27 1927, that I last saw h— alive on Feb 27 1927, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

General Peritonitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Perforated Gastric Ulcer.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Feb 27 '27

Was there an autopsy?

What test confirmed diagnosis?

(Signed) P Guerlac, M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Calvert Church Cemetery Mertins & Sons Md. Date of Burial Mar 2 1927

20 UNDERTAKER: Harry H. Nitzle

ADDRESS 1531 W Lombard St

Very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 19574

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 19574

1674

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Balto. General Hosp. ST. WARD)

2-FULL NAME Mrs. Eva Newman

(a) RESIDENCE NO. 605 N. Calhoun ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 5. 1862

7 AGE: Years 64 | Months 9 | Days 23 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Queen Anne's Co Md

PARENTS

10 NAME OF FATHER: Wm H. Sparks

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): John T Newman 605 N Calhoun st

15 - 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/28 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 23 1927 to Feb 28 1927

that I last saw her alive on Feb 28 1927

and that death occurred, on the date stated above, at 2.20 P. m.

The CAUSE OF DEATH* was as follows:

~~Cerebral Embolism~~

Cerebral Thrombosis.

(duration) Yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No Gen. Exam

What test confirmed diagnosis?

(Signed) Arnold L Jensen M. D.

2/28, 1927 (Address) W. Balto Gen. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: CRUMPTON QUEENANN Co Md

DATE OF BURIAL: 3/2 1927

20 UNDERTAKER: Robert Brooks Sons

ADDRESS: Calhoun Hollins

TION is very important. See instructions on back of certificate.

Spec.—12 9 25—A Co.—200 Bks.

# E 19575

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129 E 19575

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home & Infirmary 11-67 Ward)

2-FULL NAME James Carson Edwards

(a) RESIDENCE NO. 1619 Ellamont St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 22 - 1869

7 AGE: Years 58 | Months 1 | Days 6 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Collector
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town): Kentucky
(State or country)

PARENTS

10 NAME OF FATHER: Noah Edwards

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Kentucky

12 MAIDEN NAME OF MOTHER: Fannie Adams

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Scotland

14 Informant: Bessie Edwards
(Address) 1619 Ellamont Ave

15 1927 C. HAMPSON JONES, M. D.
Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 28 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 23 1927, to Feb 28, 1927, that I last saw h~~im~~ alive on Feb 28, 1927, and that death occurred, on the date stated above, at 12 45 P.m.

The CAUSE OF DEATH* was as follows:
Cholelithiasis

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Hyperitis, chronic Myocarditis

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Feb. 24 1927

Was there an autopsy? None Removal of Gall Stone

What test confirmed diagnosis? Operation

(Signed) Henry F. Wilson Jr. M.D., M. D.

, 19 (Address) Dr. Church Home & Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — Date of Burial: Mar 2 1927

20 UNDERTAKER: Robert Brookes Son — ADDRESS: Calhoun Hollins St

very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 19576

REGISTERED NO. 9 E 19576

1-PLACE OF DEATH

City of BALTIMORE: (No. 608 S Wolfe St St. 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Joseph Skalinski

(a) RESIDENCE NO. 608 S Wolfe St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 16 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 12 1927

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|---|
| | | 1 | 19 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None 900

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Frank Skalinski

11 BIRTHPLACE OF FATHER (City or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Frances Buczek

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Frank Skalinski
(Address) 608 S Wolfe St

15 Filed 1 - 1927 C. HAMPSON JONES, M. D. Registrar
Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1 19 27

17 I HEREBY CERTIFY, That I attended deceased from Feb. 23 1927 to March 1 1927

that I last saw him alive on March 1 1927

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Pertussis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Joseph Potorny, M. D.

. 19 (Address) 220 E Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Date of Burial March 2 1927

20 UNDERTAKER of John M Weber ADDRESS 1803 Bank St

IF DEATH IS from any but natural causes, or occurred suddenly, the property classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19577

E 19577

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST., 28-63 WARD)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME "Sister" Esther Daly

(a) RESIDENCE NO. Sacred Heart Convent Phila Pa. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 7 mos. 16 ds. How long in U. S., if of foreign birth? 47 yrs. 6 mos. 28 ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 3, 1879

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs or ..... min. |
|---|---|---|---|---|
| | 47 | 6 | 28 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sister in Convent. Home duties

(b) General nature of industry, business, or establishment in which employed (or employer): Convent

(c) Name of employer: Convent Phila. Pa.

9 BIRTHPLACE (city or town) (State or country): Patrick Daly

PARENTS

10 NAME OF FATHER: Patrick Daly

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Bridget Keegan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant (Address): Mt Hope Retreat. Mt Hope Retreat

15 MAR - 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 13, 1925, to March 1, 1927.

that I last saw her alive on March 1, 1927.

and that death occurred, on the date stated above, at 2.15 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis

(acute Cardiac Dilitation)

Unknown (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Paranoid Dementia

over (duration) 4 yrs. ~ mos. ~ ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of ~

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Milton P. Bell, M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Forrestdale, Phila Penna.

DATE OF BURIAL: Mar 3 1927

20 UNDERTAKER: STEWART & MOWEN COMPANY (Successor)

ADDRESS: 1635 W. NORTH AVE

Spec.–7-17-26—A Co.—200 Bks.

E 19578

# HEALTH DEPARTMENT—CITY OF BALTIMORE

11-004

E 19578

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of BALTIMORE: (No. 1014 William St. 24-33 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Bafford

(a) RESIDENCE NO. 1014 William St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov. 30, 1920

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|---|
| | 7 | 3 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER James Bafford

11 BIRTHPLACE OF FATHER (City or town) Calvert Co. Md.

(State or country)

12 MAIDEN NAME OF MOTHER Marcella Caldwell

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country)

14 Informant James Bafford

(Address) 1014 William St

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

By R. F. H.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1st 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 17, 1927, to March 1st, 1927, that I last saw her alive on Feb. 28, 1927, and that death occurred, on the date stated above, at 9.50 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) La Grippe

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) C. Mitchell, M. D.

19 (Address) 1279 William St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Cathedral Cem. | March 3 1927 |
| 20 UNDERTAKER Margaret J. Flynn | ADDRESS 1477 Light St. |

Fill in plain terms, so that it may be very important. See instructions on back of certificates.

Spec.–7-17-26–A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

129 E 19579

E 19579

## CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE (No. 1009 Sharp St. 23-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Henry Peppler

(a) RESIDENCE NO. 1009 Sharp St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marie A. Peppler

6 DATE OF BIRTH (month, day, and year) Jan 3. 1863

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min.. |
|---|---|---|---|---|
| | 64 | 1 | 28 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Asst. Painter

(b) General nature of industry, business, or establishment in which employed (or employer) 058

(c) Name of employer Self

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER Geo. Peppler

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Louisa Raiby

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany.

14 Informant Mrs John H. Peppler

(Address) 1009 Sharp St

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Par

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/1 1927

17 I HEREBY CERTIFY, That I attended deceased from 2/27, 1927, to 3/1, 1927.

that I last saw him alive on 2/28, 1927.

and that death occurred, on the date stated above, at 2.30 a. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Oedema

(duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary) Chr Myocarditis & Chr Nephritis (duration) yrs. chronic mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Albumin - Urine ++

(Signed) David Frankenau M. D.

3/1. 1927 (Address) 1224 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem.

Date of Burial March 4 1927

20 UNDERTAKER Margaret J. Flynn

ADDRESS 1422 Light St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 19580

## CERTIFICATE OF DEATH.

E 19580

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 17 N Schroeder St. 18 Ward)

2-FULL NAME Clara Bacon

(a) RESIDENCE NO. 17 N Schroeder St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE: Years 27 | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) _____

(State or country) Balto Md

PARENTS

10 NAME OF FATHER William Bacon

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Balto

12 MAIDEN NAME OF MOTHER Eliza Munday

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Md

14 Informant William Bacon

(Address) 17 N Schroeder St

15 Filed MAR 2 1927

C. HAMPSON JONES, M. D. Registrar

Per _____

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-27 1927

17 I HEREBY CERTIFY, That I attended deceased from 2-22-1927, to 2-27-1927, that I last saw her alive on 2-27-1927, and that death occurred, on the date stated above, at 12.40 a.m.

The CAUSE OF DEATH was as follows:

Lobar Pneumonia

(duration) ____ yrs. ____ mos. 5 ds.

CONTRIBUTORY (Secondary) _____

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? No Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? Clinical

(Signed) W. L. Carlson, M. D.

2-27-1927 (Address) 1608 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — Date of Burial: March 2/27

20 UNDERTAKER: Daniel Carlson — ADDRESS 916 Bond

very important. See instructions on back of certificates.

Spec—12-23-2:—E.B.R.S.—400 Bks.

Goodwin

E 19581

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19581

## CERTIFICATE OF DEATH.

37-001

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 617 West Barre Street 22-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Roland Goodwin

(a) Residence No. 617 West Barre Street St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married X

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Helen Goodwin

6-DATE OF BIRTH (month, day and year) 1904

7-AGE. 23

22 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer). Self

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. George Goodwin

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Annie Henson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

14-

(Informant). Helen Goodwin

(Address). 617 West Barre Street

15-

Filed 19 C. HAMILTON JONES, M. D.

MAR 2 - 1927 By H.K. Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 27th 19

17- I HEREBY CERTIFY, That I attended deceased from May 9th 1925 19 to Feb 27th 1927 19

that I last saw him alive on Feb 9th 1927 19

and that death occurred, on the date stated above, at 2:30 A m.

The CAUSE OF DEATH* was as follows:

Miliary Tuberculosis.

Several Years (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 12, 1926

Was there an autopsy? No

What test confirmed diagnosis? C. S. S.

(Signed) Harold C. Pillsbury M. D.

, 19 (Address) 31 North ve

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Zion

DATE OF BURIAL. 3-2 19 27

20-UNDERTAKER. John H. Toadvine

ADDRESS 1027 Druid Hill

Instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19582

## CERTIFICATE OF DEATH

89 E 19582

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3522 Thorne St. 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Kotch (a Racz)

(a) RESIDENCE NO. 3522 Thorne St. 23 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. da. How long in U. S. if of foreign birth? 40 yrs. mos. da.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1871 - July 23

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 55 | 7 | 5 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Austria

(State or country)

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Austria

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Austria

14 Informant Anna Kotch

(Address) 3522 Thorne St

15 Filed MAR 2 1927 C. HAMPSON JONES, M. D. Registrar

Per K. K.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 28 1926 to Feb. 28 1927

that I last saw him alive on Feb 28 1927

and that death occurred, on the data stated above, at 1:30 p. m.

The CAUSE OF DEATH* was as follows: Angina Pectoris

(duration) 2-3 yrs. mos. da.

CONTRIBUTORY (Secondary) Cardiac Dropsy

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) C. E. Rusk, M. D.

3/1/27 (Address) 408 S Potter St City.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus Cem

Date of Burial Mch 3 1927

20 UNDERTAKER Stephen Falkowski

ADDRESS 770 Hanover St

DEATH is plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

Sullivan

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19583

## CERTIFICATE OF DEATH.

3/ E 19583

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor St. 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Sullivan

(a) RESIDENCE NO. Preston & Valley St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | W | Single |

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)
1858 June 24 15

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| 69 | 68 | 8 | 4 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ireland

(State or country)

PARENTS

10 NAME OF FATHER Patrick Sullivan

11 BIRTHPLACE OF FATHER (city or town) Ireland

(State or country)

12 MAIDEN NAME OF MOTHER Mrs. Kennedy

13 BIRTHPLACE OF MOTHER (city or town) Ireland

(State or country)

14 Informant Sister Superior Little Sisters of the Poor

(Address) Preston & Valley St.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927

Feb 28th

17

I HEREBY CERTIFY, That I attended deceased from 2-28, 1927, to 2-28, 1927,

that I last saw her alive on 2-28, 1927,

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D. Bernard Lee, M. D.

3/1, 1927 (Address) 914 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — Date of Burial: Mar 2. 1927

20 UNDERTAKER: Rita Wiedefeld — ADDRESS: 914 Gramont Ave

MAR 2 - 1927 C. HAMPSON JONES, M. D. Registrar

Per

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

Henry T. Nice

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 Yrs 2 mos 6 ds

19584 REGISTERED NO. E 19584

1 PLACE OF DEATH

City of BALTIMORE: (No. 921 Montpelier St. 4-46 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry T. Nice

(a) RESIDENCE NO. 921 Montpelier St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Rosa Nice

6 DATE OF BIRTH (month, day, and year): DEC - 6 - 1863

7 AGE: Years 63 | Months 2 | Days 22 | IF LESS than 1 day.....hrs. or.....min. | 26

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Produce Dealer

(b) General nature of industry, business, or establishment in which employed (or employer): Self

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER: August Nice

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER: Ann Bone

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant: Rosa Nice

(Address) 921 Montpelier St.

15 FEB 28 1927 G. HAMPSON JONES, M. D.

Per R.C. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): February 28th 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 22nd, 1927, to Feb 28th, 1927, that I last saw h. alive on Feb 27th, 1927, and that death occurred, on the date stated above, at 11:45 a.m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilitation

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 2 yrs. .....mos. .....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Geo. Hampson Jones M.D., M. D.

3/1/1927 (Address) 406 E 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery Date of Burial: Mar 3 1927.

20 UNDERTAKER: W. B. Cook Co. ADDRESS: 502 E. North Ave.

very important. See instructions on back of certificates.

R 2

Spec.—1-10-21—M&T—1500 Bks.

E 19585

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 19585

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 106 Augusta Ave St.) (Ward) 20-7

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Gallagher

(a) RESIDENCE No. 106 Augusta Ave St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Reference yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James D. Gallagher

6 DATE OF BIRTH (month, day, and year): Aug 23 1842

7 AGE: Years 84 Months 6 Days 5 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Robert Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Buckmom

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mrs. J. Edgar Countess Sr.

(Address) 1616 W. Fayette St.

15 Filed 2-1927 C. HAMPSON JONES, M. D., Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2.28. 1927.

17 I HEREBY CERTIFY, That I attended deceased from 2.1. 1925 to 2.28. 1927.

that I last saw her alive on 2.28. 1927

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

C. Left side Hemiplegia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary): Mutual Reputation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam.

(Signed) J. Edward Norris, M. D.

3.2, 1927 (Address) 107 East West St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: 3/3 1927

20 UNDERTAKER: Chas. B. Fraver & Son

ADDRESS 1180 Mt Royal Ave

TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

159-002

## CERTIFICATE OF DEATH.

E 19586

REGISTERED NO. E 19586

1-PLACE OF DEATH

City of BALTIMORE: (No. 1729 Guilford Ave St. 12-19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Jos Martin

(a) RESIDENCE NO. 1729 Guilford Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10/15/1924

| 7 AGE Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|
| 2 | 4 | 16 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country) Md

PARENTS

10 NAME OF FATHER Wm J. Martin

11 BIRTHPLACE OF FATHER (city or town): Balto

(State or country) Md

12 MAIDEN NAME OF MOTHER Edna McElen

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country) Md

14 Informant Wm J. Martin

(Address) 1088 Gilmor St.

Filed MAR 2 - 1927

H. HIDEON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 2-1-27

17 I HEREBY CERTIFY, That I attended deceased from 2/20, 1927, to 3/1, 19 27, that I last saw him alive on 2/1, 19 27, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis Influenza

(duration) yrs. mos. 3 ds.

CONTRIBUTORY Aortic Regurgitation

(Secondary)

(duration) yrs. 3- mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) David Nigler, M. D.

3/1, 1927 (Address) 1500 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — Date of Burial 3/2. 1927

20 UNDERTAKER: Geo J. Ruth — ADDRESS 1735 Harford ave

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 19587

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

94-001

REGISTERED No. E 19587

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 430 Brice St., 20-27 Ward)

2-FULL NAME Clarence E. Thomas Jr

(a) RESIDENCE NO. 430 Brice St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

very important. See instructions on back of certificates.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: Wht

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug. 27, 26

7 AGE — Years: — Months: 6 — Days: 4 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town): Balto

(State or country): Md.

PARENTS

10 NAME OF FATHER: C. E. Thomas

11 BIRTHPLACE OF FATHER (city or town): Balto

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Edna Lee

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country): Md.

14 Informant: Mrs Edna Thomas

(Address): 430 Brice St

15 Filed ..... 19..... C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: Feby Mch 1st, 1927

17 I HEREBY CERTIFY, That I attended deceased from Feby. 8th, 1927, to Mch 1st, 1927, that I last saw h.... alive on Mch 1st, 1927, and that death occurred, on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Bronchitis. Veg. adenoids
Anemia Baby

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary): Failing heart action

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? microscopic

(Signed) [illegible], M. D.

3/1, 1927 (Address) 1005 N. Monroe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — Date of Burial: Mar 3rd 1927

20 UNDERTAKER: George Schilling & Sons — ADDRESS: 1200 Monroe St

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

47 ✓

E 19588

## CERTIFICATE OF DEATH.

REGISTERED NO. E 19588

1-PLACE OF DEATH

City of BALTIMORE: (No. 2454 W. Lanvale St., 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matilda M. Dunn

(a) RESIDENCE NO. 245 N. Luzerne Ave. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 ~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~, (write the word): Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of The late George M. Dunn

6 DATE OF BIRTH (month, day, and year) April 7-1870

7 AGE: Years 56 | Months 10 | Days 22 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Christopher Dunn

11 BIRTHPLACE OF FATHER (city or town) Not Known

(State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known

(State or country)

14 Informant George F. Dunn

(Address) 2643 E. Monument St

15 Filed.....19..... HAMPSON JONES, M. D.

Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 Feby 27th 1927

17

I HEREBY CERTIFY, That I attended deceased from Feby 21 1927 to Feby 27, 1927, that I last saw h.r alive on Feby 27, 1927, and that death occurred, on the date stated above, at 1.30 p.m.

The CAUSE OF DEATH* was as follows:

Cancer of Breast

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Coma

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

3/1/27 (Address) 1719 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cemetery Date of Burial Mar 2 1927

20 UNDERTAKER: Jas C. Miller & Son ADDRESS 1354 Jeffer[illegible]

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 19589

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31

REGISTERED No. E 19589

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 246 S. Durham st. 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Malone

(a) RESIDENCE No. 246 S Durham st. ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 19 1906.

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 20 | 2 | 9 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farming.

(b) General nature of industry, business, or establishment in which employed (or employer): 1

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Poland.

PARENTS

10 NAME OF FATHER: Antoni Malon

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland.

12 MAIDEN NAME OF MOTHER: Emilia Plakowig

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland.

14 Informant: Antoni Malon. (Address) 246 S Durham st.

15 Filed MAR 2 - 1927 C. HAMPSON JONES, M. D. Registrar Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 28 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 20, 1927, to Feb 28, 1927, that I last saw h alive on Feb 28, 1927, and that death occurred, on the date stated above, at 330 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Cardiac Palpus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William T. Rypanek M. D.

(Address) 801 Hanover st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary. DATE OF BURIAL: March 3 1927

20 UNDERTAKER: George A. Weber ADDRESS: 2205 Bank st

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19590

## CERTIFICATE OF DEATH.

129 E 19590

1-PLACE OF DEATH Union Memorial Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 33rd (Mateus) or Calvert Street, 2591 ST., 1 WARD)

2-FULL NAME Mr. Mathews Gryber GRIBAS

(a) RESIDENCE No. 813 Pennington Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. — mos. ds. How long in U. S., if of foreign birth? 28 yrs. — mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced (Mateus) HUSBAND of (or) ~~WIFE of~~ Mrs. Mathews Gryber

6 DATE OF BIRTH (month, day, and year) May 5, 1874

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 52 | 9 | 26 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia LITHVANIA

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) LITHVANIA

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) LITHVANIA

14 Informant Mrs. M. Gribas

(Address) 813 Pennyton Ave.

15 Filed MAR 2 - 1927 C. HAMPTON JONES, M. D. Registrar

Per R.K.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1, 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb. 28, 1927, to March 1, 1927, that I last saw him alive on March 1, 1927, and that death occurred, on the date stated above, at 7-40 A.m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic nephritis

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis, Blood chem

(Signed) J. C. Greci, M. D.

, 19 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Holy Cross A.A. | March 5. 1927 |

20 UNDERTAKER ADDRESS

John Grebliauckas J.G. 423 S. Paca St.

Cor.—12-9-25—A Co.—200 Bks.

E 19591

# HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 19591

## CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1742 E. Balto., St St., 6-9 Ward)

2-FULL NAME Moses Paul

(a) RESIDENCE NO. 1742 E. Balto., St St. _____ Ward _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: ~~Mulo~~ ~~colr~~

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Florence Paul

6 DATE OF BIRTH (month, day, and year): unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 63 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailor

(b) General nature of industry, business, or establishment in which employed (or employer): 080

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country): Russia

PARENTS

10 NAME OF FATHER: Frank Paul

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country): Russia

14 Informant: Ellis Paul

(Address): ~~1601 Edgendson Ave~~

15 Filed 19 _____ Registrar

R 2-1927 G. HAMILTON JONES, M.D.

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 Mar 1/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) Inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Chr Myocarditis

_____ (duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) History-Angina Pectoris

_____ (duration) ____ yrs. ____ mos. ____ ds.

(Signed) _____ M. D.
(Coroner)

3/2/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale

Date of Burial: 3/7 1927

20 UNDERTAKER: Jack Levin

ADDRESS 1439 E Monument

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19592

## CERTIFICATE OF DEATH.

90 E 19592

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2645 Lehmann ST., 20th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Rider

(a) RESIDENCE No. 2645 Lehmann ST., 20th WARD

(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. 5 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Rider

6 DATE OF BIRTH (month, day, and year) Sept 21-1854

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 72 | 5 | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington, D. C.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md

14 Informant Mary E. Rider

(Address) 2645 Lehmann St

15 Filed MAR 2 - 1927

C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27th 1927

17 I HEREBY CERTIFY, That I attended deceased from 19 Feb, 1927, to Feb 27, 1927.

that I last saw h er alive on 27 Feb 1927

and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Z. Vance Hooper, M. D.

28 Feb. 1927 (Address) Balto. 2025 Frata

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL March 1 1927

20 UNDERTAKER F. B. Hufnagel

ADDRESS 1850 W. Balto St

FOR INFORMATION. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

E 19593 E 19593

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

1-PLACE OF DEATH — REGISTERED NO. 1320 90

City of BALTIMORE: (No.) 807 Lenox St. (Ward) 13

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Rosenthal

(a) RESIDENCE No. 807 Lenox St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. — mos. — ds. How long in U. S. if of foreign birth? 19 yrs. — mos. — da.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Max

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 62 — Months: — — Days: — — IF LESS than 1 day ... hrs. or ... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Russia

(State or country)

PARENTS

10 NAME OF FATHER: Schrie Rosenthal

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Russia

12 MAIDEN NAME OF MOTHER: Frank Esther

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Russia

14 Informant (Address): Max Rosenthal 807 Lenox st

15 Filed 3/2 1927 C. HAMPSON JONES, M. D. Registrar

Per R L

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/2 1927

17 I HEREBY CERTIFY, That I attended deceased from 3/1, 1927, to 3/2, 1927, that I last saw h[illegible] alive on 3/2, 1927, and that death occurred, on the date stated above, at 5 30 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Valvular disease of Heart

(duration) 2 yrs. mos. da.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

3/2/27 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Southern Ave — Date of Burial 3/2 1927

20 UNDERTAKER: Sol Levinson & Bro — ADDRESS 1127 E Balto st

very important. See instructions on back of certificates.

ARL - 1027

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19594

## CERTIFICATE OF DEATH.

32 E 19594

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital, 1521 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Smith

(a) RESIDENCE NO. 1612 Vincent St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | col | single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) Dec 13/1923

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 3 | 2 | 15 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Bernard Sorrell

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Md.

12 MAIDEN NAME OF MOTHER Irene Smith

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) St. Mary's Co Md.

14 Informant Hopkins Record

(Address) _____

MAR 2 - 1927 HAMPSON JONES, M. D.

15 Filed _____ Per _____ Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 Feb 28/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Meningitis (Tuberculer)

(No autopsy)

_____ (duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) _____

_____ (duration) ___ yrs. ___ mos. ___ ds.

(Signed) J. H. Bailey M. D.

(Coroner)

3/2/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery Date of Burial March 2 1927

20 UNDERTAKER Mrs. J. H. Dennis per J. E. K. ADDRESS 1303 Eastern Ave

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 19595

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 E 19595

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 928 South Binney ST. 1-1 WARD)

2-FULL NAME MARIA ZMUDIEJEWSKI,

(a) RESIDENCE NO. 928 South Binney ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. 1 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female, | White, | Single, |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 2-1906.

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 21 | 1 | 27 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tin Decorating,

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Tin Decorating Co. Boston St.

9 BIRTHPLACE (city or town) (State or country) Baltimore, MD.

PARENTS

10 NAME OF FATHER Jacob Zmudiejewski,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, MD.

12 MAIDEN NAME OF MOTHER Josephine Wielinski,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, MD.

14 Informant Mrs. Josephine Zmudiejewski,

(Address) 928 S. Binney Street

15 Filed 1927. 19 C. HAMPSON JONES, M. D.

Per Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 20 .1927. to March 1 .1927.

that I last saw h[illegible] alive on March 1 .1927.

and that death occurred, on the date stated above, at 3.30 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Cardiac Dyspepsia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Rysanek M. D.

(Address) 801 N. Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ST. STANISLAUS CEMETERY

DATE OF BURIAL Mar. 4- 1927.

UNDERTAKER M. F. Sadowski.

ADDRESS 705 S. Ann St

R2

THIS is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 19596

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

90

E 19596

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1335 Hanover St. 23-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm H. McKew.

(a) RESIDENCE NO. 1335 Hanover St. Ward 23

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced. (write the word): Widowed

5a If married, widowed, ~~or divorced~~ HUSBAND of (or) ~~WIFE of~~: Mary Lacey

6 DATE OF BIRTH (month, day, and year): July 23, 1851

7 AGE: Years 75 Months 7 Days 1 IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Watchman

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Wm. H. Lewis

11 BIRTHPLACE OF FATHER (City or town) Maryland.

(State or country)

12 MAIDEN NAME OF MOTHER Ellen Hanagan

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant Nellie Tibbs

(Address) 1335 Hanover St.

15 Filed FEB 2 1927 19 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 28 19 27.

17 I HEREBY CERTIFY, That I attended deceased from Feb 20. 19 27. to Feb 28 19 27.

that I last saw h[illegible] alive on Feb 28 19 27.

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Chr. Valvular Endocarditis

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted

If not at place of death? No.

Did an operation precede death? No. Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John A. Schenuit M. D.

19 (Address) 1337 St. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bridal Veil — Date of Burial 3/3 1927

20 UNDERTAKER: J. F. Lahey & Son — ADDRESS 35 Light St

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19597

## CERTIFICATE OF DEATH.

129

REGISTERED NO. E 19597

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1610 E. Fort ave. ST. 24-35 WARD)

(If death occurred in hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edmund O Brien

(a) RESIDENCE NO. 1610 E. Fort av ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. — mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | white | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ellen Elizabeth O Brien

6 DATE OF BIRTH (month, day, and year) March 29, 1857

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 69 | 11 | 2 1 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired gd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER John O Brien

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Redmond.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Elizabeth Duigate
(Address) 1610 E Fort ave

15 Filed MAR 2 - 1927 19 C. HAMPSON JONES, M. D. Registrar
Per

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 27, 1927, to Mch 1, 1927, that I last saw him alive on Feb. 28, 1927 and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Uraemic Coma

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? Date of

Was there an autopsy? None

What test confirmed diagnosis? Hist

(Signed) Chas L Stevens, M. D.

3/1, 1927 (Address) 2218 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. National Cem. DATE OF BURIAL March 4, 1927

20 UNDERTAKER Chas. L. Stevens ADDRESS 1501 E Fort Ave

TION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

19598

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

51 ✓

E 19598

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 112 E Barney St., 24-34 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Wedemyer.

(a) RESIDENCE NO. 112 E. Barney St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 3[illegible] yrs. mos. ds. How long in U. S. If of foreign birth? 3[illegible] yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male. | White. | Single. |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan, 27, 1888.

| 7 AGE | Years | Months | Days |
|---|---|---|---|
| | 39, | 1, | 2. |

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boiler Maker.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany.

PARENTS

10 NAME OF FATHER Gustav Wedemyer.

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Annie Miller.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany.

14 Informant Annie Wedemyer, (Mother).

(Address) 112 E. Barney Street.

Filed MAR 2 - 1927 19 H. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3—1 19 27

17 I HEREBY CERTIFY, That I attended deceased from 1—11—27 to 3—1—27

that I last saw h[illegible] alive on 2—28—27

and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Acute Mitral Insufficiency

(Rheumatic)

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. 1 mos. ds.

18 Where was disease contracted

If not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) T. Ruth Dunton M. D.

(Address) 608 Mt. Vernon Pl.

3-1-27

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem Woods, Date of Burial 1927

20 UNDERTAKER C. Howard Evans ADDRESS 38 E Fort Ave

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

162

E 19599

REGISTERED NO. E 19599

1. PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 13-59 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Rosen

(a) RESIDENCE NO. 2906 Parkwood Ave St. [illegible] Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3/1/27.

7 AGE — Years | Months | Days | IF LESS than 1 day 11 hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: [illegible]

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Joseph Rosen

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Bessie Karsek

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Joseph Rosen

(Address) 2906 Parkwood ave

15 Filed MAR 2 - 1927

S. C. HAMPSON JONES, M. D.
Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

3-1-27

17

I HEREBY CERTIFY, That I attended deceased from 3-1, 1927, to 3-1, 1927,

that I last saw her alive on 3-1, 1927

and that death occurred, on the date stated above, at 4.20 P m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Harry Weintraub, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew [illegible]dale Date of Burial 3/2 1927

20 UNDERTAKER: Jack Bemis ADDRESS 1432 Balto

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

2.00674

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19600

PLACE OF DEATH

## CERTIFICATE OF DEATH.

25-79

REGISTERED NO. E 19600

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lorraine Crumblers

(a) RESIDENCE NO. 41 Adaskin. Curtis Bay ST. Md WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9 mos. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Baby |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of dec'd 18 1925

6 DATE OF BIRTH (month, day, and year) No Record

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min |
|---|---|---|---|---|
| | 1 year | 2 | 13 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Curtis Bay Md

PARENTS

10 NAME OF FATHER Konrad Crumblers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pro

12 MAIDEN NAME OF MOTHER Mary Paleles

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Parents

(Address)

15 Filed 2-1927 JOHNS HOPKINS HOSPITAL M. D. (SIGNATURE) Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 1 1927.

17 I HEREBY CERTIFY, That I attended deceased from Feb. 28, 1927, to Mar. 1, 1927, that I last saw h[illegible] alive on Mar. 1, 1927 and that death occurred, on the date stated above, at 11:30 P m

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 4(?) ds.

CONTRIBUTORY (Secondary) Pertussis Varicella (duration) yrs 1½ mos. 2 wks. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) H. E. Handley, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL 3-3 1927

20 UNDERTAKER E & B Hale — ADDRESS 115 E West St.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19601 E 19601

## CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1408 Park Ave., ST., 14-20 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Matilda Brewer

(a) RESIDENCE NO. 1408 Park Ave., ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. ? 1852

| 7 AGE | Years | Months | Days | If LESS than 1 day, .... hrs. or .... min. |
|---|---|---|---|---|
| | 75 | 2 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) D.C.
(State or country)

PARENTS

10 NAME OF FATHER Henry Brewer

11 BIRTHPLACE OF FATHER (city or town) D.C.
(State or country)

12 MAIDEN NAME OF MOTHER Susan Jones

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Mrs. Wm. B. Rogers
(Address) 1408 Park Ave.

15 Filed 1927 By C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3.1. 1927

17 I HEREBY CERTIFY, That I attended deceased from 2.28, 1927, to 3.1, 1927,
that I last saw her alive on 3.1, 1927,
and that death occurred, on the date stated above, at 30, m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

3.3. 1927 (Address) 211 W. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Loudon Park Cemetery | March 3 1927 |

| 20 UNDERTAKER | ADDRESS |
|---|---|
| Chas. E. Franck | 802 Madison Ave |

Cor.—1-12-23—M&T—100 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19602 E 19602

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1112 Thompson ST., 5-8 WARD)

REGISTERED NO. 101

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Juniour Oliver

(a) RESIDENCE No 1112 Thompson ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| male | Colored | married |

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Oliver

7 DATE OF BIRTH (month, day, and year) 1883

| AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| 44 | 43 | | | |

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Fertilizer Co
(c) Name of employer

BIRTHPLACE (city or town) Va
(State or country)

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) unknown

Informant Mary Oliver
(Address) 809 Hartford Ave

Filed MAR 2 - 1927 C. HAMPSON JONES, M. D. Registrar
By .....

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Pneumonia (lobar)

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

(Signed) J S H Owen, M. D.
(Coroner.)

March 2/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Auburn Cemetery | Mar 4 1927 |
| UNDERTAKER | ADDRESS |
| Chas. H. Thomas & Co. | Carolin Ft |

Spec.-7-17-26—A Co.—200 Bks.

E·19603

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

101-001

E·19603

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No.) 3826 Fremont ave St., 10-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patrick J. Mc Andrew

(a) RESIDENCE NO. 3826 Fremont ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 11-1884

7 AGE — Years: 42 Months: 11 Days: 17 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Labor Gen'l

(b) General nature of industry, business, or establishment in which employed (or employer): Bag Business

(c) Name of employer: American Chemical Co

9 BIRTHPLACE (city or town): City

(State or country)

PARENTS

10 NAME OF FATHER: Patrick J. Mc Andrew

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Ireland

12 MAIDEN NAME OF MOTHER: Hannah Hennigan

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Ireland

14 Informant: Bessie Mc Andrew

(Address) 3826 Fremont ave

15 1927 C. HAMPSON JONES, M. D.

Per RRH Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 Feb 27

17 I HEREBY CERTIFY, That I attended deceased from Feb 26, 1927, to Feb 27, 1927.

that I last saw h alive on Feb 27, 1927

and that death occurred, on the date stated above, at 10 17 m.

The CAUSE OF DEATH* was as follows:

L. Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death? Place of Death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. L. Burke, M. D.

19 (Address) Feb 25, 27 3042 Henderson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery

Date of Burial: 3/3/ 1927

20 UNDERTAKER: J. J. Moran

ADDRESS: 3007 E Baltimore

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 19604

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19604

## CERTIFICATE OF DEATH.

101-007

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1407 N Fayette (St.) 11-27 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian B Forsyth

(a) RESIDENCE No. 1407 N Fayette ST., ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: J. K. Forsyth

6 DATE OF BIRTH (month, day, and year): Sept 23- 1890

7 AGE: Years 36 Months 5 Days 9 If LESS than 1 day, ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Clarksburg W. Va.

PARENTS

10 NAME OF FATHER: J. H Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Fredericks Md

12 MAIDEN NAME OF MOTHER: Matilda Knight

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Highland W. Va

14 Informant: J. K Forsyth

(Address): 1407 N Fayette St

15 1927 C. HAMPSON JONES, M. D.

Per ..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3 - 2 - 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 28, 1927, to March 1, 1927, that I last saw h[illegible] alive on March 1, 1927, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward A Morgan M. D.

3/2, 1927 (Address) 1335 N Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: CLARKSBURG WVA

DATE OF BURIAL: Mar 4 1927

20 UNDERTAKER: Robert Brooks & Son

ADDRESS: Baltimore Md

ATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

19605

## CERTIFICATE OF DEATH.

E 19605

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 607 So. Monroe St. 14-28 Ward)

2-FULL NAME Chas E. Yingling

(a) RESIDENCE NO. 607 So. Monroe St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minervia Yingling

6 DATE OF BIRTH (month, day, and year) Aug 28th 1862

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 64 | 6 | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Building Supt

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) _____ (State or country) Md

PARENTS

10 NAME OF FATHER Wm Yingling

11 BIRTHPLACE OF FATHER (city or town) _____ (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) _____ (State or country) Md

14 Informant Paul M. Yingling (Address) 4322 Mitchell Ave

15 Filed _____ 19___ C. HAMPSON JONES, M. D. Registrar

1927 Per _____

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy at once

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) _____ (duration) ___ yrs. ___ mos. ___ ds.

(Signed) Thos B. Horton M. D. (Coroner)

Feb 28 1927 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pipe Creek Cemetery Brooklyn Md Date of Burial Mar 3 1927

20 UNDERTAKER H M Routson ADDRESS 2238 N Howard St

very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19606

# CERTIFICATE OF DEATH.

48 E 19606

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1019 Falls Road St., 13 57 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roy C. Kershaw

(a) RESIDENCE NO. 1011 Union Ave. St. 13 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. 5 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Bessie L. Kershaw

6 DATE OF BIRTH (month, day, and year): Sept. 30 - 1887

7 AGE — Years: 39 — Months: 5 — Days: 1 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Pipe Fitter

(b) General nature of industry, business, or establishment in which employed (or employer): B. & O. R.R. Co.

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md.

PARENTS

10 NAME OF FATHER: Edwin Kershaw

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Maryland

12 MAIDEN NAME OF MOTHER: Martha McFaul

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Maryland

14 Informant: Mrs. Bessie L. Kershaw

(Address): 1011 Union Ave.

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 1- 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 21, 1926, to March 1, 1927, that I last saw him alive on March 1, 1927, and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stom (Pyloric end) Peritonitis (Over)

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) General metastasis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted? —

If not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? Before

What test confirmed diagnosis?

(Signed) Wilson G, M. D.

March 4 1927 (Address) 342 Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL* Druid Ridge — Date of Burial March 4 1927

20 UNDERTAKER — ADDRESS Horace F. Burgee 363 Falls Road

very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

# E 19607.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

# E 19607

## CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1010 Roland Heights Ave. St. 13-52 Ward)

2-FULL NAME Melville A. Shaw

(a) RESIDENCE NO. 1010 Roland Heights Ave St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 8 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 22-1924

7 AGE: Years 2 | Months 8 | Days 9 7 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md

PARENTS

10 NAME OF FATHER: Percy Shaw

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Maryland

12 MAIDEN NAME OF MOTHER: Martha B Arthur

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Maryland

14 Informant: Percy Shaw

(Address): 1010 Roland Heights Ave

15 Filed 2-7-27, 19 C. HAMPSON JONES, M. D. Registrar

By _____

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 1- 19 27.

17 I HEREBY CERTIFY, That I attended deceased from Feb. 14, 1927, to March 1, 1927, that I last saw h alive on March 1, 1927, and that death occurred, on the date stated above, at 11 40 A. m.

The CAUSE OF DEATH* was as follows:

a Acute Cardiac Dilatation

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical signs

(Signed) Frank Hruska, M. D.

, 19 (Address) 4637 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cem Date of Burial: March 3 1927

20 UNDERTAKER: Horace H. Burgee ADDRESS: 3631 Falls Road.

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19608

E 19608

## CERTIFICATE OF DEATH.

REGISTERED NO. 73 E 19608

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2203 Barclay St. 12-50 Ward)

2-FULL NAME N. Elizabeth Hann

(a) RESIDENCE NO. 2203 Barclay St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed or divorced HUSBAND of (or) WIFE of John E. Hann

6 DATE OF BIRTH (month, day, and year) Jan. 9- 1872

| 7 AGE | Years | Months | Days | If LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 55 | 1 | 19 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Carroll Co. Md.

(State or country)

PARENTS

10 NAME OF FATHER Arthur Fill

11 BIRTHPLACE OF FATHER (city or town) Carroll Co. Md.

(State or country)

12 MAIDEN NAME OF MOTHER Catherine Stockdale

13 BIRTHPLACE OF MOTHER (city or town) Carroll Co. Md.

(State or country)

14 Informant John E. Hann

(Address) 2203 Barclay St.

15 Filed ..... 1927 C. HAMPSON JONES, M. D. Registrar

Per .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 28- 1927

17 I HEREBY CERTIFY, That I attended deceased from May, 1926, to Feb 28, 1927, that I last saw her alive on Jan 19. 1927 and that death occurred, on the date stated above, at 9.30 A m.

The CAUSE OF DEATH* was as follows:

Progressing Muscular Atrophy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bulbar Palsy

(duration) yrs. mos. ds.

18 Where was disease contracted Baltimore

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Muscular Palsy

(Signed) W. H. Dearden M. D.

. 19 (Address) 2105 N. Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Garrettown, Md March 3 1927

20 UNDERTAKER Jordan H. Burgee ADDRESS 363 Hall Road

very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19609

## CERTIFICATE OF DEATH.

101-001

E 19609

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1422 E Madison St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Wallace

(a) RESIDENCE NO. 1422 E Madison St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown 1891

7 AGE: Years 36; Months; Days; If LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASER

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): 03

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Md.

PARENTS

10 NAME OF FATHER: Jas Spencer

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Md

12 MAIDEN NAME OF MOTHER: Laura Richards

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Balto md

14 Informant (Address): William Wallace 1422 E Madison St

15 Filed 2-28-1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 27 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 21, 1927, to Feb 27, 1927, that I last saw h[illegible] alive on Feb 26, 1927, and that death occurred, on the date stated above, at 8 am m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Softening, Heart failure

Toxemia 7 d. (Duration) ..... yrs. ..... mos. ..... ds. Hemiplegia 3 Days

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) J. Edward Fisher, M. D.

2-28 1927 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mag[illegible] Co. Md. Date of Burial 3-3 1927

20 UNDERTAKER: Jas. M. Skinner ADDRESS 1620 E. Madison

very important. See instructions on back of certificate.

19610

# HEALTH DEPARTMENT—CITY OF BALTIMORE

19610

## CERTIFICATE OF DEATH.

1 90

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1407 Linden Ave 14-70 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marian. C. Spedden

(Residence in Baltimore: No. 1407 Linden Ave St.: yrs. mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Unknown (Month), 1 (Day) (Year)

7-AGE, about 80 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John. H Spedden

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER M. L. Morgan

13-BIRTHPLACE OF MOTHER (State or Country) Talbot Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. A. O. Tucker Cathy

(Address) 6 E. Pleasant St

15-

Filed 1927 C. HAMPSON JONES, M. D. Registrar.

Per

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February (Month) 28 (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) found that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Circulatory Disturbance Heart Age (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner)

3/2, 1927 (Address) 30 Holland St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cem

DATE OF BURIAL, March 3, 1927

39-UNDERTAKER Henry H Jenkins Son & Co

ADDRESS Eighteen Hundred Block E Baltimore St

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19611

CERTIFICATE OF DEATH.

101-001

E 19611

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 113 Brapton St. 11-24 Ward)

2-FULL NAME Mary Teackle Harris

(a) RESIDENCE NO. 113 Brapton St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced: HUSBAND of (or) WIFE of Frank Harris

6 DATE OF BIRTH (month, day, and year): July 4 1886

7 AGE: Years 40 | Months 7 | Days 24 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer): Domestic

(c) Name of employer

9 BIRTHPLACE (city or town): Anacostia

(State or country): Va

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Unknown

12 MAIDEN NAME OF MOTHER: Alice Duckett

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Va

14 Informant: Mary Wiggins

(Address): 1324 Druid Hill Ave

15 Filed: 1927 C. HAMPSON JONES, M. D. Registrar

Par

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 28 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 26 1927, to Feb 28, 1927, that I last saw h alive on Feb 28, 1927, and that death occurred, on the date stated above, at 11.50P m.

The CAUSE OF DEATH* was as follows:

Bilateral Lobar Pneumonia

(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. Mc Lai, M. D.

3/1, 1927 (Address) 1126 Druid Hill

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Conn

Date of Burial: March 3/1927

20 UNDERTAKER: Harry Tarbert

ADDRESS: Laurel

Very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19612

## CERTIFICATE OF DEATH.

3 | E 19612

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2906 Overland ave ST. 2-44 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie M. Goeb

(a) RESIDENCE NO. 2906 Overland ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, or ~~Divorced~~, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: late John Goeb

6 DATE OF BIRTH (month, day, and year): Dec 15 1863

7 AGE

| Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|
| 63 years | 2 | 13 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Lorenz Knorr

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Annie Knoerlein

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Maria Meister

(Address) 2906 Overland ave

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

2 - 1927 Feb 26

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 26 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 6, 1927. to Feb 26 1927.

that I last saw h alive on Feb 26 1927

and that death occurred, on the date stated above, at m

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Diabetes Mellitus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas Smith, M. D.

19 (Address) 4702 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery

DATE OF BURIAL: 3 | 2 | 1927

20 UNDERTAKER: George J. Rutt

ADDRESS: 1736 Harford Ave.

Spec.—1-10-21—M&T—1500 Bks.

E 19613

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19613

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2057 E Federal ST., 8-17 WARD)

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Weissing Sr.

(a) RESIDENCE NO. 2057 E Federal ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Kroll

6 DATE OF BIRTH (month, day, and year) Nov 25-184

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 65 | 3 | 7 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Night Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Weissing

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Adamus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Minnie Weissing

(Address) 2057 E Federal St

15 FILED 1927 C. HAMPSON JONES, M. D. Registrar

19 Per ORH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 2 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 1st, 1927, to Mar 2nd, 1927.

that I last saw him alive on Mar 1st, 1927.

and that death occurred, on the date stated above, at 9:30 a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis & Arterio-sclerosis.

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Isaac Druckman M. D.

3/7, 1927 (Address) 846 W 36th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem

DATE OF BURIAL Mar 7 1927

20 UNDERTAKER John Ellis

ADDRESS 858 Cham

Spec.—1-10-21—M&T—1500 Bks.

E 19614

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 19614

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2501 E Monument St., 1-10 WARD)

2-FULL NAME August Pahl

(a) RESIDENCE NO. 2501 E Monument ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Divorced |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 12, 1857

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 69 | 6 | 12 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Horse Trainer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Aug. Pahl Sr

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhelmina Lehmann

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Germany

14 Informant Mrs A Pahley

(Address) 1708 Lutheran St

15 Filed 2-1927 C. HAMPSON JONES, M. D. Registrar

Per O.K.H.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 1. 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov. 12, 1926, to Mar. 1, 1927, that I last saw h[illegible] alive on March 1, 1927 and that death occurred, on the date stated above, at 8 - a m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Trouble

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) William Kepaver M. D.

19 (Address) 882 W Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

DATE OF BURIAL Mar 4 1927

20 UNDERTAKER John Ellis & Son

ADDRESS 2628 Eutaw

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19615

## CERTIFICATE OF DEATH.

91-22

E 19615

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1603 Mt. Elden ST., 7-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Wagner

(a) RESIDENCE NO. 1603 Mt. Elden ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Zimmerman

6 DATE OF BIRTH (month, day, and year): April 1856

7 AGE — Years: 70 — Months: 11 — Days: — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machine Hand

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Louis Wagner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dora Kuhn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. Mary Wagner

(Address): 1603 Mt. Elden

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

By: RKB

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 1927

17 I HEREBY CERTIFY, That I attended deceased from February 16, 1927 to March 1, 1927.

that I last saw him alive on March 1st, 1927, and that death occurred, on the date stated above, at 6:05 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Asthenia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Sol. H. Jones, M. D.

March 2, 1927 (Address) 1601 E. Eager St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

DATE OF BURIAL: May 1927

20 UNDERTAKER: John Leonick

ADDRESS: 28 E. Eager

Cor.—12-9-25—A Co.—200 Bks.

E 19616

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19616

## CERTIFICATE OF DEATH.

182

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Harbor Post of Hill St. 27-6 Ward)

2-FULL NAME John L Hurst

(a) RESIDENCE NO. 1116 Church St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Theresa Hurst

6 DATE OF BIRTH (month, day, and year): April 17 1879

7 AGE: Years 47 Months 10 Days 14 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country)

PARENTS

10 NAME OF FATHER: Patrick A. Hurst

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Ireland

12 MAIDEN NAME OF MOTHER: Alice V. Wildesorrow

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Va

14 Informant: Mrs. August W. Hurst

(Address): 703 Hanover St.

15 Filed May 5 1927 C. HAMPSON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 1 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Drowning (Accd)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Physical

(duration) yrs. mos. ds.

(Signed) Geo Edmund Radcliffe M. D.

(Coroner)

May 5 1927 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery Md Date of Burial 19 27

20 UNDERTAKER: F. A. Kraus Son ADDRESS 703 Hanover St

Very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19617

## CERTIFICATE OF DEATH.

E 19617

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Sundry

CITY OF BALTIMORE: (No. 1003 S Robison ST., 1-1 WARD)

2-FULL NAME Andrzej Budzynski

(a) RESIDENCE NO. 1003 S Robison ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine Budzynski

6 DATE OF BIRTH (month, day, and year) Nov 1837

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 69 | 3 | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Fertilizer Works

(c) Name of employer

9 BIRTHPLACE (city or town) not known

(State or country) Austria Poland

PARENTS

10 NAME OF FATHER Budzynski

11 BIRTHPLACE OF FATHER (city or town) not known

(State or country) Austria Poland

12 MAIDEN NAME OF MOTHER Maryann

13 BIRTHPLACE OF MOTHER (city or town) not known

(State or country) Austria Poland

14 Informant Josephine Budzynski

(Address) 1003 S Robison

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 14, 1927, to Feb 27, 1927.

that I last saw h— alive on Feb 27, 1927.

and that death occurred, on the date stated above, at 6:50 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(

(duration) yrs. mos 13 ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

3/1, 1927 (Address) 1014 S. Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cemetery Hillsdale DATE OF BURIAL March 2 1927

20 UNDERTAKER Wendell Riffel & Son ADDRESS 37 S —

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19618

## CERTIFICATE OF DEATH.

74-601

E 19618

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5608 East ave. WARD 1-2)

2-FULL NAME Annie M Lunz

(a) RESIDENCE NO. 5608 East ave WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | W | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 2 1861

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 66 | 1 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Keeping

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Conrad Lunz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Lunz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna M. Bolle

(Address) 5611 East ave

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2 1927

17 I HEREBY CERTIFY, That I attended deceased from March 2, 1927, to March 2, 1927,

that I last saw her alive on March 2, 1927,

and that death occurred, on the date stated above, at 2.20 p. m.

The CAUSE OF DEATH* was as follows:

Paralysis (over)

(duration) ..... yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ..... yrs. mos. 1 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? Phy Exam

(Signed) Geo C Lintz Blades M. D.

3-7-1927 (Address) 142 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Holy Redeemer | March 5 1927 |
| 20 UNDERTAKER Wendell Diffendal | ADDRESS 3705 Fr |

Cor.—12-9-25—A Co.—200 Bks.

Stiles

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-01

E 19619

E 19619

## CERTIFICATE OF DEATH.

18-26

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 970 Franklin Rd St. 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Stiles

(a) RESIDENCE NO. 972 Franklin Rd St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) Jan 24-1927

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | | 1 | 5 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Bal'd

(State or country) Md

PARENTS

10 NAME OF FATHER George Stiles

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Katherine Kuatta

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant George Stiles

(Address) 970 Franklin Rd.

15 1927 C. HAMPSON JONES, M. D.

Reg. _____ Registrar

Very important. See instructions on back of certificate.

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an enquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said enquiry (Inquest, autopsy or inquiry,) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) ____ yrs. ____ mos. 4 ds.

CONTRIBUTORY (Secondary) no other contrib

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. T. Hennessey, M. D. (Coroner)

Mar 2 1927 (Address) 2502 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Date of Burial 3/2 1927

20 UNDERTAKER Harry A Wright ADDRESS 1531 W Lombard

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19620

166 E 19620

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital St., 9-1 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Augusta Hensler

(a) RESIDENCE NO. 1833 Harford Ave St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George W. Hensler

6 DATE OF BIRTH (month, day, and year) Jan 30/1885

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 42 | 1 | 1 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At home.

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER George Werner

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Germany

12 MAIDEN NAME OF MOTHER Minnie Frank

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Germany

14 Informant George Hensler

(Address) 1833 Harford Ave

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per RCC

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 1/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bichloride Mercury Poisoning (Suicide)

(duration) .....yrs. .....mos. 4 .....ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) .....yrs. .....mos. 2 .....ds.

(Signed) J. K. Pallen M. D.

(Coroner)

3/2/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.....mos.,.....ds.

Where was disease contracted, if not at place of death?_____

Former or usual residence_____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem. Date of Burial March 5 1927

20 UNDERTAKER John C. Miller ADDRESS 2435 E. Oliver

Very Important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19621

## CERTIFICATE OF DEATH.

E 19621

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 208 N. Amity St. Ward) 16-76 101-00

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Ross Gross

(a) Residence No. 208 N. Amity St St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Col.

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Aug. 28, 1909

7-AGE. 17 yrs. 5 mos. 20 ds. If LESS than 1 day, ....hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) Taylor Shop

(c) Name of employer.....

9-BIRTHPLACE (city or town). (State or Country). Calvert Co., Md.

PARENTS.

10-NAME OF FATHER. George Gross

11-BIRTHPLACE OF FATHER (city or town). (State or Country). Calvert Co., Md.

12-MAIDEN NAME OF MOTHER. Charlotte Gross

13-BIRTHPLACE OF MOTHER (city or town). (State or Country). Calvert Co., Md.

14- (Informant) Minnie Stimpett

(Address) 2347 N. Amity St.

15- Filed 3 1927 C. HAMILTON JONES, M. D. Registrar.

By RK

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3-1-27

17- I HEREBY CERTIFY, That I attended deceased from Feb. 26 1927 to March 1, 1927 that I last saw him alive on Feb. 28, 1927 and that death occurred, on the date stated above, at 7.30 P. m. The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H. Marco Williams M. D.

3-2, 1927 (Address) 1830 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Calvert Co

DATE OF BURIAL. Mar 3 1927

20-UNDERTAKER. Lottie Gross

ADDRESS 1405 Mcculloh St

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 19622 162 ✓ E 19622

1-PLACE OF DEATH E 19622

CITY OF BALTIMORE: (No. 1033 Mount St. WARD) 16-32

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Carter

(a) RESIDENCE No. 1033 Mount ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years | Months | Days: 5 hours | If LESS than 1 day, ..... hrs. ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): 1033 Mount St Baltimore Md

PARENTS

10 NAME OF FATHER: Alexander Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Nottaway Co. Va.

12 MAIDEN NAME OF MOTHER: Carline Henry.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Richmond Co. Va.

14 Informant (Address): Alexander Carter (mother) 1033 Mount.

15 Filed ....., 19 ..... Registrar

C. HAMILTON JONES, M. D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/27/1927

17 I HEREBY CERTIFY, That I attended deceased from 2/27/1927 to 2/27/1927 that I last saw him alive on 2/27/1927 and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) yrs. mos. 5 hours ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. Alexander Rowley M. D.

, 19 (Address) 1516 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL: MAR 2 - 1927

20 UNDERTAKER

ADDRESS

Deputy Commissioner Health.

UNIVERSITY OF MARYLAND

Cor.—12-9-25—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19623

## CERTIFICATE OF DEATH.

161-002 E 19623

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 510 Forest St. 5-8 Ward)

2-FULL NAME Coriuale Cimino

(a) RESIDENCE NO. 510 Forest St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Mar 2, 1919

7 AGE — Years — Months — Days — IF LESS than 1 day.....hrs. or 10 min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): child
(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore
(State or country)

PARENTS

10 NAME OF FATHER S. Cimino

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Italy

12 MAIDEN NAME OF MOTHER S. Brocato

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Italy

14 Informant: S Brocato
(Address): 510 Forest

15 Filed 1927 C. HAMPSON JONES, M. D.
Per R.K. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mch 2. 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxia due to Cord around neck in child-birth

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) None

(duration) .....yrs. .....mos. .....ds.

Mch (Signed) A. J. Riley M. D.
(Coroner)
, 19 27 (Address) 1059 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

St Vincents Cem. 3/3 27

20 UNDERTAKER — ADDRESS

Geo J Ruth 1735 Harford ave

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19624

## CERTIFICATE OF DEATH.

129

E 19624

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1201 N Calvert ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME R. Brent Keyser

(a) RESIDENCE NO. 1201 N. Calvert ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred from birth ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | white | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ellen McHenry Keyser

6 DATE OF BIRTH (month, day, and year) Aug 5th 1859

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 67 | 6 | 26 25 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired manufacturer

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER William Keyser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Mary Hoke Brent

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hagerstown, Md

14 Informant C. McHenry Keyser

(Address) 1205 N. Calvert St

15 Filed MAR 3 - 1927 C. HAMILTON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1 19 27

17 I HEREBY CERTIFY, That I attended deceased from October 15, 1926, to March 1, 1927,

that I last saw him alive on March 1, 1927,

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

acute myocardial insufficiency

(duration) yrs. 4 mos 15 ds.

CONTRIBUTORY (Secondary) chronic nephritis

(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jay Martin, M. D.

, 19 (Address) 12 East Eager

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Greenmount Cem | March 3rd 19 27 |
| 20 UNDERTAKER | ADDRESS |
| Henry H. Tenkins Sons | [illegible] |

Cor.—12-9-25—A Co.—200 Bks.

E 19625

# HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

## CERTIFICATE OF DEATH.

REGISTERED NO. E 19625

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 314 Canal St 11 24 Ward)

2-FULL NAME Kate Kenwick

(a) RESIDENCE NO. 314 Canal St St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1847

7 AGE: Years: about 80 Months: Days: If LESS than 1 day .....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore Md.

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town): Unknown

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town): Unknown

(State or country)

14 Informant: Mrs Estelle Young

(Address) 1821 Druid Hill Ave

15 Filed ....., 19..... C. HAMPSON JONES, M. D.

Per _____ Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 1, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Arterio sclerosis

(duration) 2 yrs. ..... mos. ..... ds.

(Signed) S. T. Kennedy M. D.
(Coroner)

March, 1927 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ..... mos., ..... ds. In the State ..... yrs., ..... mos., ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem

Date of Burial: 3/3 1927

20 UNDERTAKER: Samuel Kennedy

ADDRESS: W Balto

Spec.—1-12-23—M&T—500 Bks.

E 19626

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

11 E 19626

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1207 E. Madison ST. 11-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jerome Allen

(a) RESIDENCE NO. 1207 E. Madison ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | Col. | S |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 1919

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 7 | 6 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Thomas Allen

11 BIRTHPLACE OF FATHER (city or town) Richmond (State or country) Va.

12 MAIDEN NAME OF MOTHER Jessie Saunders

13 BIRTHPLACE OF MOTHER (city or town) Richmond (State or country) Va.

14 Informant Thomas Allen

(Address) Forbes

15 Filed APR 3 - 1927, 19 H. HAMPSON JONES, M. Registrar

By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 28 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 23, 1927, to Feb. 28, 1927, that I last saw h[illegible] alive on Feb. 28, 1927, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

gangrenous appendicitis

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) General Peritonitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam

(Signed) W. L. Rafferty, M. D.

, 19 (Address) 1510 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Cem. DATE OF BURIAL 3/3/27

20 UNDERTAKER Wm. A. Elliott ADDRESS 1725 Ashland

Spec—12-23-21—E.B.R.S.—400 Eks.

Rich ✓

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19627 E 19627

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH 1629 E. Madison St 7-13 17 Registered No.....

City of BALTIMORE: (No. 1629 East Madison St., ..... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Robert Rich

(a) Residence No. 1629 East Madison St., 7 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

| 3-SEX. | 4-COLOR OR RACE. | 5-Single, Married, Widowed, or Divorced. (Write the word.) |
|---|---|---|
| Male | Colored | Married |

5a-If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Mary Rich

6-DATE OF BIRTH (month, day and year) April 26, 1868

7-AGE. 58 yrs. 10 mos. 2 ds. If LESS than 1 day, ....hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... Odd
(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Va.
(State or Country),

PARENTS.

10-NAME OF FATHER. John Rich

11-BIRTHPLACE OF FATHER (city or town) Maryland
(State or Country),

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... Feb 28 1927
(State or Country), Unknown

14-(Informant) Mary Rich (wife)
(Address) 1629 E. Madison St.

15-Filed MAR 3 - 1927 HAMPSON JONES, M. D. Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb. 28, 1927

17. I HEREBY CERTIFY, That I attended deceased from Jan. 2, 1927 to Feb. 28, 1927.
that I last saw him alive on Feb. 27th, 1927.
and that death occurred, on the date stated above, at 11-55 a.m.
The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis
.....
.....
.....
To my knowledge (Duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis
Unknown (Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? Home & Local
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Usual clinical tests

(Signed) A. D. Macdonald M. D.
Feb 28, 1927 (Address) 1540 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19-PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL. |
|---|---|
| Mt. Calvary | 3/3/27 19.... |
| 20-UNDERTAKER, Wm. R. E. Ellis | ADDRESS 122 W. Lanvale |

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19628

## CERTIFICATE OF DEATH.

E 19628

REGISTERED NO.

1-PLACE OF DEATH Johns Hopkins Hospital

CITY OF BALTIMORE: (No. 17-50 ST. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Brogdon

(a) RESIDENCE NO. 323 E. 23rd St. ST. City WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 15 1926

7 AGE: Years | Months 4 | Days 17 | If LESS than 1 day, hrs. or min.

5 mos 18

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER James Brogdon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga.

12 MAIDEN NAME OF MOTHER Nannie Royal

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ga.

14 Informant Records - 1

(Address) JOHNS HOPKINS HOSPITAL

15 Filed MAR 3 - 1927 by C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb 26, 1927, to March 1, 1927, that I last saw him alive on March 1, 1927 and that death occurred, on the date stated above, at 1.50 a. m.

The CAUSE OF DEATH* was as follows:

Ante Primary Pneumonia (Lobar)

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 323 E. 23rd St.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. E. Handley, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary — DATE OF BURIAL: 3/3/27

20 UNDERTAKER: Wm. A. G. Elliott — ADDRESS: 1725 Eastern

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19629

## CERTIFICATE OF DEATH.

8-17 74001

REGISTERED NO. E 19629

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1327 N. Chapel ST. ..... WARD)

2-FULL NAME Estelle Russell

(a) RESIDENCE NO. 1327 N. Chapel ST., ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Uncertain

7 AGE: Years abt. 65 | Months | Days | If LESS than 1 day, .... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): North Carolina

PARENTS

10 NAME OF FATHER: Jacob Myers

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. Carolina

12 MAIDEN NAME OF MOTHER: Rebecca Byrd

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. Carolina

14 Informant: John Russell

(Address) 1327 N Chapel

15 Filed ..... 19.. C. HAMPSON JONES, M. D. Registrar

KJ - 1321 Per .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3 - 1 1927

17

I HEREBY CERTIFY, That I attended deceased from Feby 24, 1927, to Feby 25, 1927, that I last saw h/ alive on Feby 25, 1927 and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Medical Attendance

(Signed) E. Walters, M. D.

, 19 (Address) 1635 N Eldern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary

DATE OF BURIAL: 3/3/27

20 UNDERTAKER: Mrs. P. G. Elliott

ADDRESS 1725 Ashland Av.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19630

## CERTIFICATE OF DEATH.

49

REGISTERED NO. E 19630

1-PLACE OF DEATH

City of BALTIMORE: (No. 7 N. Duncan St. 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna E. Roesslein

(a) RESIDENCE NO. 7 N. Duncan St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Michael Roesslein

6 DATE OF BIRTH (month, day, and year) Aug 21 1875

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 51 | 6 | 8 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country)

PARENTS

10 NAME OF FATHER Leopold Schmidt

11 BIRTHPLACE OF FATHER (city or town) Ger.

(State or country)

12 MAIDEN NAME OF MOTHER Mary Trunk

13 BIRTHPLACE OF MOTHER (city or town) Ger.

(State or country)

14 Informant Mr. Michael Roesslein

(Address) 7 N. Duncan

Filed ..... 19 ..... C. HAMPSON JONES, M. D.

By ..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927

March 1—

17 I HEREBY CERTIFY, That I attended deceased from Jan 13 1927, to March 1, 1927, that I last saw h.. alive on March 1, 1927, and that death occurred, on the date stated above, at 11:40 A.m.

The CAUSE OF DEATH* was as follows:

Hypernephroma Lt Kidney

(duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) Metastasis to Lungs

(duration) ..... yrs. 2 mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray

(Signed) N. L. Salander, M. D.

, 19 (Address) 3030 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Date of Burial March 5 1927

20 UNDERTAKER Jos. F. Herr ADDRESS 1564 N. Luzerne

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19631 ~~South Balto~~ Gen. Hosp.

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH 1213 S. Legatt St. 26-39

REGISTERED NO. E 19631

City of BALTIMORE: (No. _____ St., _____ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Ethel L. Culberson.

(a) RESIDENCE NO. 3515 Philadelphia Road St. _____ Ward Baltimore, Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: O. Culberson

6 DATE OF BIRTH (month, day, and year): 1898

7 AGE: Years 28 | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country) Maryland

PARENTS

10 NAME OF FATHER Samuel Thomas

11 BIRTHPLACE OF FATHER (city or town):

(State or country) England

12 MAIDEN NAME OF MOTHER Margaret Green

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) England

14 Informant Husband.

(Address) 3515 Philadelphia Road

15 Filed MAR 3 - 1927 16 [illegible] Registrar

B.—W... do... OF... very... important...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1, 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1927, to March 1927, that I last saw h[illegible] alive on March 1, 1927, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) Bronco pneumonia

(duration) _____ yrs. _____ mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Feb 24, 1927

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. E. Miller, M. D.

, 19 (Address) 1211 Bolton St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn — Date of Burial March 5 1927

20 UNDERTAKER: Jos. J. Iderr — ADDRESS 156 N. Luzerne

[illegible] M. D.

Spec.—1-10-21—M&T—1500 Bks.

E 19632

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19632

## CERTIFICATE OF DEATH.

74-002

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hospital ST. 16-16 WARD)

2-FULL NAME George Porter

(a) RESIDENCE NO. 1313 W. Fayette ST., ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | Single Married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 2, 1876

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 50 | 9 10 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Draftsman

(b) General nature of industry, business, or establishment in which employed (or employer) 080

(c) Name of employer

9 BIRTHPLACE (city or town) Newark
(State or country) Delaware

PARENTS

10 NAME OF FATHER Geo. J. Porter

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland -

12 MAIDEN NAME OF MOTHER Ellen Cook

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Delaware

14 Informant Hospital Chart
(Address)

15 Filed MAR 3 - 1927 HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/2 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec. 23, 1926, to Mar. 2, 1927,

that I last saw him alive on Mar. 2, 1927,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Prostatic Hypertrophy. 135

(duration) ..... yrs. 5 mos ..... ds.

CONTRIBUTORY (Secondary) Cerebral embolism

(duration) 0 yrs. 0 mos. 5 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes Date of 12/31/26 2/21/27

Was there an autopsy? No

What test confirmed diagnosis? Operative, Lab.

(Signed) John A. Kemp M. D.

(Address) 1313 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Ark Delaware

DATE OF BURIAL Mch 3 1927

20 UNDERTAKER John Oursler

ADDRESS 1820 W. Fayette St.

Spec.—1-10-21—M&T—1500 Bks.

E 19633 ✓ E 19633

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. +47

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hospital St. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Mary Silver

(a) RESIDENCE NO. Havre de Grace Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Fem. | White | Single. |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) July 14 1849

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs. or ....min. |
|---|---|---|---|---|
| | 77 | 7 | 16 | 18 |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Hartford County (State or country) Maryland

PARENTS

10 NAME OF FATHER Benj. Silver

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Randall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Self.

(Address)

15 Filed APR 3 - 1927 HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/2 1927

17 I HEREBY CERTIFY, That I attended deceased from 12/9, 1926, to 3/2, 1927, that I last saw her alive on 3/2, 1927, and that death occurred, on the date stated above, at 7 40 a.m.

The CAUSE OF DEATH* was as follows:

Carcinomatosis of abdomen & left breast;

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cachexia and Toxemia

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Home -

Did an operation precede death? yes Date of 12/14/26 Removal left breast

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab.

(Signed) Hampson Jones, M. D.

, 19 (Address) 1101 Guilford Ave X.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Harmony Hartford Co. DATE OF BURIAL Feb 4 1927

20 UNDERTAKER John C. Mitchell ADDRESS 120 W Fayette St.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

24-31 188-003 E 19634

19634

REGISTERED NO._____

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of BALTIMORE: (No. South Baltimore General Hospital Ward)

2-FULL NAME Lila May Jackson.(C)

(a) RESIDENCE NO. 168 N. Hamburg St. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 11 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female. | Colored | Single. |

3a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) March 8, 1921

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 5 | 11 | 24 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Thomas J. Jackson, Jr. (C)

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Portsmouth Va.

12 MAIDEN NAME OF MOTHER Matilda Turner. (C)

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Charles Co. Md.

14 Informant Matilda Jackson. (C) mother.

(Address) 168 N. Hamburg St.

Filed MAR 3 - 1927 C. HAMPSON JONES, M. D. Registrar

Per RR

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feoruary 27, 1927 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: fracture of the skull, struck, knocked down and run over by an automobile, while crossing Hanover St at Montgomery St. Occidental Death. (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto Reinhardt M. D. (Coroner)

3/8 · 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Hanover & Montgomery Sts. Feb. 27, 1927

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Ct — Date of Burial March 3 1927

20 UNDERTAKER C. W. L. Brandenburg ADDRESS 108 W. Monday St

Spec—12-23-21—E.B.R.S.—400 Bks.

19635

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 19635

1-PLACE OF DEATH

City of BALTIMORE: (No. 772 Washington Boulevard St. ..... Ward) 0427 Mt 001

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Laura Kimmel

(a) Residence No. 772 Washington Boulevard St., ..... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Anna M. Kimmel

6-DATE OF BIRTH (month, day and year) Nov 26th 1842

7-AGE. 84 yrs. 3 mos. 6 ds. If LESS than 1 day ..... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ..... Metal Workes

(b) General nature of industry, business, or establishment in which employed (or employer) ..... 054

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Germy.

PARENTS.

10-NAME OF FATHER. Franz Kimmel

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germy

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germy

14- (Informant) Elizabeth Kimmel

(Address) 772 Washington Blvd.

15- Filed 3 - 1927 C. HAMPSON JONES, M. D. Registrar. By R H

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Mar 2/27

17- I HEREBY CERTIFY, That I attended deceased from Feb. 1 1927 to March 2 1927

that I last saw him alive on March 1 1927

and that death occurred, on the date stated above, at 7 30 a m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis

(Duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Apoplexy

(Duration) 3 hrs. am mos. ..... ds.

18-Where was disease contracted if not at place of death? ——

Did an operation precede death? no Date of ——

Was there an autopsy? no

What test confirmed diagnosis? Physical Ex

(Signed) J. M. Lamperin M. D

3/3, 1927 (Address) 826 N Carrollton

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cem. DATE OF BURIAL. March 5th 1927

20-UNDERTAKER. E Schloman & Son ADDRESS 1024 Edmonson Ave

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

15-001

E 19636

REGISTERED NO. E 19636

1-PLACE OF DEATH

City of BALTIMORE: (No. 1610 Mc Culloh St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Jones

(a) RESIDENCE NO. 1610 Mc Culloh St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Colored | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1857

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min.. |
|---|---|---|---|---|
| 70 | 69 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Bruintown

(State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town) Unknown

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown

(State or country)

14 Informant Annie Kennaugh

(Address) 1610 Mc Culloh St

15 Filed MAR 3 - 1927 By C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1— 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan-25 1927. to March-1 1927.

That I last saw h[illegible] alive on March 1— 1927.

and that death occurred, on the date stated above, at 5:45 p m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Right Hemiplegia

(duration) yrs. 6 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. Coleman, M. D.

Mar 3 1927 (Address) 1738 Mc Culloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount

Date of Burial 3/3 1927

20 UNDERTAKER Samuel McDermott Son & Bridle

ADDRESS 518

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002

E 19637
1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

E 19637
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 811 S. Payson ST. 20-28 WARD)

2-FULL NAME Isaac Thomas

(a) RESIDENCE NO. 811 S Payson ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Josephine Thomas

6 DATE OF BIRTH (month, day, and year): April 10, 1862

7 AGE: Years 64 | Months 10 | Days 18 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Janitor
(b) General nature of industry, business, or establishment in which employed (or employer): Camden Warehouse
(c) Name of employer: Retired 074

9 BIRTHPLACE (city or town) (State or country): Ohio

PARENTS

10 NAME OF FATHER: Aaron Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ohio

12 MAIDEN NAME OF MOTHER: Stokes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ohio

14 Informant: Josephine Thomas
(Address): 811 S. Payson St.

15 Filed: MAR 3 1927 19 Per: H. C. HAMPTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/28 19 27

17 I HEREBY CERTIFY, That I attended deceased from 2/24, 1927, to 2/28, 19 27.

that I last saw h living on 2/28, 19 27.

and that death occurred, on the date stated above, at 7.00 P.M.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) 2 days

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) years mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Howard Kelly, M. D.

3/2 19 27 (Address) 1207 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery Inc. DATE OF BURIAL: 3/3 1927

20 UNDERTAKER: George L. Schwatka & Son ADDRESS: Eutaw

Spec.—1-10-21—M&T—1500 Bks.

19638

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

44

E 19638
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) Provident Hospital (St.) 19-27 (Ward)

2-FULL NAME Emma Reed

(a) RESIDENCE NO. 111 N Mount ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem
4 COLOR OR RACE: Colored
5 Single, Married, Widowed, ~~or Divorced. (write the word)~~: Widowed

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Not Known

6 DATE OF BIRTH (month, day, and year): April 18. 1866

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 60 | 10 | 10 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laundress
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Howard Co Md

PARENTS
10 NAME OF FATHER: Wm Oliver
11 BIRTHPLACE OF FATHER (city or town) (State or country): Md
12 MAIDEN NAME OF MOTHER:
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Ella Eccles
(Address) 1214 Ethan St

15 Filed 3-1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feby 28 1927

17 I HEREBY CERTIFY, That I attended deceased from Feby 3 1927 to Feby 28 1927, that I last saw her alive on Feby 28 1927, and that death occurred, on the date stated above, at 4P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the liver
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) W. T. Woodall, M. D.
3/2 1927 (Address) 1911 Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Md. Mem Cemetery
DATE OF BURIAL: Mar. 3 1927
20 UNDERTAKER: J. E. M. Johnson
ADDRESS 1284 Etting St.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 19639

## CERTIFICATE OF DEATH.

E 19639
1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Bress. City Hospital St. 24-33)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Cook

(a) RESIDENCE NO. 621 E. Clement St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 1844

| 7 AGE | Years | Months | Days | IF LESS than 1 day....hrs. or....min. |
|---|---|---|---|---|
| | 83 | 1 | - | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Allegheny Co

(State or country) Maryland.

PARENTS

10 NAME OF FATHER John Finley

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann O'Brien

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Interment

(Address) John F. Finley 621 E. Clement St.

15 Filed MAR 3 1927 By C. HAMDEN JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-2-27

17 I HEREBY CERTIFY, That I attended deceased from 10-23, 1926, to 3-2, 1927, that I last saw h.. alive on 3-1, 1927, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

~~Myocardial failure~~
Myocardial Insufficiency

(duration) 0 yrs. 1 mos. 0 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) 0 yrs. 0 mos. 14 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes 3-4-27

What test confirmed diagnosis? Autopsy

(Signed) ~~R. H. Smith~~ R. Wood Smith M. D.

, 19 (Address) Bress. City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem. Date of Burial March 5 1927

20 UNDERTAKER Margaret H. Flynn ADDRESS 1422 Light St.

E 19640

Spec. 1511-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

49

REGISTERED No. E 19640

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St. 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Miller

(a) RESIDENCE NO. 201 N. Patterson Park St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, ~~Widowed, or~~ Divorced, (write the word): ~~ow~~ Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Getta Miller

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE: Years 57 Months Days IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: not given

(b) General nature of industry, business, or establishment in which employed (or employer): Tailor

(c) Name of employer

9 BIRTHPLACE (city or town): Russia

(State or country)

PARENTS

10 NAME OF FATHER: Benj. Miller not given

11 BIRTHPLACE OF FATHER (City or town): Poland

(State or country)

12 MAIDEN NAME OF MOTHER: Sarah Snyder

13 BIRTHPLACE OF MOTHER (city or town): Russia

(State or country)

14 Informant: Getta Miller

(Address) 201 N. Patterson Park

15 Filed 3-4 1927 19 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-3 1927

17 I HEREBY CERTIFY, That I attended deceased from 12-14, 1926, to 3-3, 1927, that I last saw him alive on 3-3, 1927, and that death occurred, on the date stated above, at 4 08 9 m.

The CAUSE OF DEATH* was as follows:

Pulmonary embolism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma Antrum

Highmore, right (duration) yrs. 6 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of 3-1-27

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) J. Theron Hunter M. D.

3/3 1927 (Address) St. Agnes' Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lehran Mash. Road — Date of Burial 3/4 1927

20 UNDERTAKER: Jack Levin — ADDRESS 1439 E. Balt. St.

Key Important: See Instructions on Back of Certificate

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19641

1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

E 19641

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (a) NO. 1630 Madison Ave (b) WARD

2-FULL NAME Richard Hall

(a) RESIDENCE NO. 1630 Madison Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | C | Married |

5a If married, widowed, or divorced HUSBAND of (or WIFE) Mary Emma Hall

6 DATE OF BIRTH (month, day, and year) Aug 25, 1878

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| 48 | 49 | 6 | 3 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engine Cleaner

(b) General nature of industry, business, or establishment in which employed (or employer) Western Md RR.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Edward Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Susie Maddox

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs Mary Emma Hall (wife)

(Address) 1630 Madison Ave

15 Filed MAR 3 - 1927 By R. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan . 1926 . to Feb 28 . 1927 .

that I last saw h alive on Feb 27 . 1927 .

and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Bladder

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R Jeffery M. D.

3/2 . 1927 (Address) 429 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Cemetery

DATE OF BURIAL 3/4/27

UNDERTAKER Wm. H. G. Elliott

ADDRESS 1724 Eutaw

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19642

101-001

## CERTIFICATE OF DEATH

E 19642

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hospital St. 15-68 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Lampe

(a) RESIDENCE NO. 1614 Ashburton St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 76 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Lampe

6 DATE OF BIRTH (month, day, and year) April 29/52

7 AGE 45 Years 10 Months 11 Days IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk U.S.P.O.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) City

(State or country)

PARENTS

10 NAME OF FATHER Everhardt F. Lampe

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ger

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Anna L. Lampe

(Address) 1614 Ashburton St

15 Filed MAR 3 - 1927 C. HAMILTON JONES, M. D. Registrar

For R. H.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-1 1927

17 I HEREBY CERTIFY, That I attended deceased from 2-23 1927, to 3-1 1927

that I last saw him alive on 3-1 1927

and that death occurred, on the date stated above, at 7.20 a. m.

The CAUSE OF DEATH* was as follows:

LOBAR PNEUMONIA

(duration) yrs. mos 6 da.

CONTRIBUTORY (Secondary) PULMONARY EDEMA

(duration) yrs. mos 1 da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? PHYSICAL SIGNS

(Signed) WPL Wilson, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Date of Burial 3/4 19

20 UNDERTAKER Richard Breyer ADDRESS 1620 Ashburton St

Very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 19643 HEALTH DEPARTMENT—CITY OF BALTIMORE E 19643

## CERTIFICATE OF DEATH.

REGISTERED NO. 75-001 1861

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) No. 2118 W. Lexington St. (b) Ward 20th

2-FULL NAME Edward L. Sauter.

(a) RESIDENCE No. 2118 W. Lexington St. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth 50 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Franz. Sauter.

6 DATE OF BIRTH (month, day, and year) Feb 21st 1861

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 65 | 3 | 9 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Herman Freyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Kesterke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Adam C. Tile (Address) 3029 Druid Park and

15 Filed 1927 C. HAMPSON JONES, M. D., Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2 1927

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1926, to Mar 2, 1927

that I last saw h. alive on Mar 1, 1927,

and that death occurred, on the date stated above, at 7.30 p. m.

The CAUSE OF DEATH* was as follows:

Hypertension and Nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis + Hemiplegia

(duration) 2 yrs. mos ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Howard Sauter M. D.

3/2 1927 (Address) 2027 W. Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery DATE OF BURIAL Mar 5th 1927

UNDERTAKER F. B. Wilfert ADDRESS 850 N. Carey St

Spec.—1-10-21—M&T—1500 Bks.

Richardson ✓

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19644

E 19644

## CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 137 W Preston St. (WARD) 23-31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Ellen Richardson

(a) RESIDENCE NO. 137 W Preston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John W Richardson

6 DATE OF BIRTH (month, day, and year) Apr 28 1858

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 68 | 10 | 4 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Aquasco Md

PARENTS

10 NAME OF FATHER Thomas Ball

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Tubman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Phoebe Rhoades

(Address) (2) W Lund

15 Filed Mar 4 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 2 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 22 1927 to Mar 2 1927.

that I last saw h alive on Mar 2 1927,

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Chronic int nephritis with cardio vascular disease

(duration) unknown yrs. mos ds.

CONTRIBUTORY (Secondary) Angina pectoris

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Path

(Signed) W M Kelly M. D.

3/4, 1927 (Address) 131 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Brandywine Md | Mar 4 1927 |
| 20 UNDERTAKER John F. Denny | ADDRESS 715 Light St |

Spec.-7-17-26—A Co.—200 Bks.

E·19645

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E·19645

## CERTIFICATE OF DEATH

11-001

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 2005 N La Fayette St. 46-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William S. Barbee Jr

(a) RESIDENCE NO. 2005 N La Fayette St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | — |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 25 - 1925 -

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ... min.. |
|---|---|---|---|---|
| | 1 | 7 | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER William S Barbee Sr.

11 BIRTHPLACE OF FATHER (City or town) Baltimore

(State or country)

12 MAIDEN NAME OF MOTHER Mattie A Miller

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country)

14 Informant William S Barbee Jr

(Address) 2005 N La Fayette

15 Filed 1927 — C. HAMPSON JONES, M. D. Registrar

Per —

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3 1927

17 I HEREBY CERTIFY, That I attended deceased from February 15, 1927, to March 3 - 1927.

that I last saw him alive on March 3 - 1927.

and that death occurred, on the date stated above, at 5-00 a.m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) — yrs. — mos. 12 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) — yrs. — mos. 17 ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) Chester Riland, M. D.

3-3-1927. (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Loudon Park | Mch 5 - 1927 |

| 20 UNDERTAKER | ADDRESS |
|---|---|
| Fullum Co | 502 E Fayette |

Very Important. See instructions on back of Certificate.

Cor.—12-9-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19646 ✓ 159-002 E 19646

## CERTIFICATE OF DEATH.

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 600 N. Glover St., 7-10 Ward)

2-FULL NAME "Girl" Simon

(a) RESIDENCE NO. 600 N Glover St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 1/27

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | | | | 4 |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Bally Mt

(State or country)

PARENTS

10 NAME OF FATHER John Simon

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Slovakia

12 MAIDEN NAME OF MOTHER Rosie Klement

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Czechoslovakia

14 Informant

(Address) 600 N. Glover St.

15 Filed C. HAMPSON JONES, M. D. Registrar

MAR 9 1927 12:00 RECD

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Congenital Debility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. S. H. Paller M. D.
(Coroner)

3/11/27 (Address) 508 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 19

20 UNDERTAKER ADDRESS

JOHNS HOPKINS HOSPITAL MAR 8 1927

Commissioner of Health

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19647

E 19647

## CERTIFICATE OF DEATH.

139

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Maryland General Hospital

CITY OF BALTIMORE: (NO. ..... ST. 8-16 WARD)

2-FULL NAME Mrs Anna Bensel

(a) RESIDENCE NO. 1716 N. Collington Ave ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Fem. | W. | Married |

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Leo. Bensel

6 DATE OF BIRTH (month, day, and year) Jan. 20, 1884

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 43 | 1 | 5 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H.W. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Robert Stamm

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Switzerland

12 MAIDEN NAME OF MOTHER Eliz. Klein

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Hospital Record.
(Address)

15 Filed ... 1927 ... 19 ... C. HAMPSON JONES, M. D. Registrar
By ...

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/3 1927

17 I HEREBY CERTIFY, That I attended deceased from 2/20/27, 19 ... to 3/3, 19 27.

that I last saw her alive on 3/3, 19 27,

and that death occurred, on the date stated above, at 3 15 a.m.

The CAUSE OF DEATH* was as follows:

Fibro myoma of uterus

(duration) ... yrs. 3 mos ... ds.

CONTRIBUTORY (Secondary) Peritonitis with Toxemia

Card. Decomp. (duration) ... yrs. ... mos. 2. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? ~~Yes~~ No Date of 2/23/27.

Was there an autopsy? No.

What test confirmed diagnosis? Clinical & Lab.

(Signed) J. Hampson Jones M. D.

, 19 (Address) Md. Gen. Hospl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL May 7, 1927

20 UNDERTAKER John Merrick — ADDRESS 2028 Eden

spec.—1-12-23—M&T—500 Blks.

19648

# HEALTH DEPARTMENT—CITY OF BALTIMORE

19648

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Lee Shettle

(a) RESIDENCE NO. 4525 Arlington Ave ST., WARD Resident

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 9 mos. 3 ds. How long in U. S., if of foreign birth? 1 yrs. 9 mos. 3 ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 30, 1925

7 AGE

| Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|
| 1 | 9 | 3 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Hunter R Shettle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Catherine Price

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cecil Co Md.

14 Informant Mrs. H. R. Shettle

(Address) 4525 Arlington ave

15 Filed 1927, 19 Per ORS C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 21, 1927, to March 3, 1927, that I last saw him alive on March 3, 1927, and that death occurred, on the date stated above, at 10½ a m.

The CAUSE OF DEATH* was as follows:

Tonsillar & Pharyngeal Diphtheria

(duration) yrs. mos 13 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical spec. & Bact

(Signed) Myron G. Tull, M. D.

3/3, 1927 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and 12) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Port Deposit DATE OF BURIAL March 3, 27

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19649 E 19649

## CERTIFICATE OF DEATH.

78

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST. 28-63 WARD)

2-FULL NAME Ida Stewart

(a) RESIDENCE NO. Mt Hope Retreat ST., ..... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 28. 1859

7 AGE

| Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|
| 68 | 4 | 25 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Duncan Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary E. Griffith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant (Address) Mt Hope Retreat Mt Hope Retreat

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3 1927.

17 I HEREBY CERTIFY, That I attended deceased from Sept 1 1925 to March 3 1927.

that I last saw h alive on March 2 1927

and that death occurred, on the date stated above, at 1.30 p m.

The CAUSE OF DEATH* was as follows:

Epilepsy

(acute Cardiac failure).

(duration) unknown yrs. mos ds.

CONTRIBUTORY (Secondary) Dementia

(duration) 30 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Milton P. Hill M. D.

, 19 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL March 5/27

20 UNDERTAKER STEWART & MOWEN COMPANY

ADDRESS 808 N NORTH AVE

spec.—1-12-23—M&T—500 Blks.

E 19650 HEALTH DEPARTMENT—CITY OF BALTIMORE E 19650

11-001

# CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1324 Eutaw Place ST. 11-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anne Pinkney

(a) RESIDENCE NO. 1324 Eutaw Place ST., WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. 6 mos. 1 ds. How long in U. S., if of foreign birth? 80 yrs. 6 mos. 1 ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

6a If married, widowed, or divorced HUSBAND of (or) WIFE of (Single)

6 DATE OF BIRTH (month, day, and year) Sept.-1-1846

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 80 | 6 | 1 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (City or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Frederick Rinkney

11 BIRTHPLACE OF FATHER (city or town) (At Sea)

(State or country) Atlantic Ocean

12 MAIDEN NAME OF MOTHER Sophia Rodgers

13 BIRTHPLACE OF MOTHER (city or town) Harford Co.

(State or country) Maryland

14 Informant Miss Ethel R. Gray (Niece)

(Address) 1324 Eutaw Place City.

15 Filed ..., 19... C. HAMPSON JONES, M. D.

1927 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3.2 1927

17 I HEREBY CERTIFY, That I attended deceased from 2.26, 1927, to 3.2, 1927, that I last saw h[illegible] alive on 3.2, 1927, and that death occurred, on the date stated above, at 3.40 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) L. D. Stewart, M. D.

3.3. 1927 (Address) 211 W. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL March 4th 1927

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor)

ADDRESS 103 W. NORTH AVE.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19651

## CERTIFICATE OF DEATH.

101-01

E 19651

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 15-21 Ward)

2-FULL NAME Samuel Barber

(a) RESIDENCE NO. 1823 Kavanaugh St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | col | single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXXX

6 DATE OF BIRTH (month, day, and year) 8, 27, 26

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | | 6 | 24 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md

PARENTS

10 NAME OF FATHER Samuel Barber

11 BIRTHPLACE OF FATHER (city or town)

(State or country) St. Marys Co.

12 MAIDEN NAME OF MOTHER Emma Price

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto. Md.

14 Informant Hopking Record

(Address)

15 Filed....., 19..... HAMILTON JONES M. D.

Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 1/27 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) Inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Primary Pneumonia
(Probably Lobar)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) [signature] M. D.

(Coroner)

3/2/27 (Address) 508 E. NorthAve

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery Date of Burial Mar. 4. 1927

20 UNDERTAKER Mrs. Jos. F. Dennis Rel. F. D. ADDRESS 303 Pennsylvania Ave

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19652

CERTIFICATE OF DEATH.

× 90

E 19652

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2421 Barclay St. 12-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry A. Raymond

(a) RESIDENCE NO. 2421 Barclay St. Ward Aiken Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 30 1843

7 AGE: Years 83 | Months 7 8 | Days 2 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md

(State or country)

PARENTS

10 NAME OF FATHER Samuel W Raymond

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Lenox

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md.

14 Informant Harry A Raymond

(Address) 2421 Barclay St. Balto Md

15 1927 C. HAMPSON JONES M. D. Registrar

Per B K B

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 29 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 25 1926, to Mar 29 1927

that I last saw him alive on Mar 29 1927

and that death occurred, on the date stated above, at 11-30 P m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Same.

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical sign

(Signed) W H Pedrick, M. D.

, 19 (Address) 2105 Eliza St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ivy City Cemetery Hartford Co. Md. Date of Burial 1927

20 UNDERTAKER: Henry Fanning & Son ADDRESS: Aberdeen Md

Spec.—12-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19653

## CERTIFICATE OF DEATH.

57 E 19653

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2223 Maryland Ave. St. 12-51 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William C. Long

(a) RESIDENCE NO. 2223 Maryland Ave. St. Ward

(Usual place of abode) Lifetime

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna V. Long.

6 DATE OF BIRTH (month, day, and year): Sept. 12th. 1861

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 65 | 5 | 21 19 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Straw Hat Business

(b) General nature of industry, business, or establishment in which employed (or employer): Supt.

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Johns

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Margaret Culnan

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto. Md.

14 Informant: Anna V. Long.

(Address) 2223 Maryland Ave.

15 1927 C. HAMPSON JONES, M. D.

Per Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

March 3rd. 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 1 1926 to Mar 3, 1927, that I last saw him alive on Mar 3, 1927, and that death occurred, on the date stated above, at 7 10 a.m.

The CAUSE OF DEATH* was as follows: Myocardial Insufficiency rapid dilatation

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Diabetes mellitus

(duration) 1 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James E. Schmunk M. D.

(Address) 4012 Park Heights Ave

3-3, 19 27

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery. Date of Burial 3/5 1927

20 UNDERTAKER: Chas. H. Evans & Son ADDRESS 1180 Mt Royal Ave

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19654

CERTIFICATE OF DEATH.

E 19654

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 726 W. Lexington St. 18-76 Ward

2-FULL NAME James W. Hood

(a) RESIDENCE NO. 726 W. Lexington St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of): Mary E. Hood

6 DATE OF BIRTH (month, day and year): Feb 3, 1874.

7 AGE: Years 53; Months -; Days 29; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Millhand

(b) General nature of industry, business, or establishment in which employed (or employer): Odk

(c) Name of employer

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER: James Hood

11 BIRTHPLACE OF FATHER (city or town): Md

(State or country)

12 MAIDEN NAME OF MOTHER: Emma Hood

13 BIRTHPLACE OF MOTHER (city or town): Md

(State or country)

14 Informant: Mary E. Hood

(Address): 726 W. Lexington St

15 Filed 3-7-1927 C. HAMPSON JONES, M. D. Registrar

Pat

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/5/27 19

17

I HEREBY CERTIFY, That I attended deceased from 2/25/27, 19..., to 3/5/27, 19...,

that I last saw h.... alive on 3/5/27, 19...,

and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows: Chronic Nephritis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & Chronic Disease.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis? —

3/7, 1927 (Signed) Clement J. Fenn, M. D.

(Address) 910 N. Linden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Marys Hampden Date of Burial: March 9 1927

20 UNDERTAKER: Chenowethon

ADDRESS: 3615 Chestnut Ave

19655

# HEALTH DEPARTMENT—CITY OF BALTIMORE

19655

## CERTIFICATE OF DEATH.

66

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 401 Principio Place 12-5th ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edna E. Gunnavan

(Residence in Baltimore: No. 401 Principio Place St., 20 yrs., ..... mos. ..... ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

| 3-SEX. | 4-COLOR OR RACE. | 5-Single, Married, Widowed, Divorced. (Write the word.) |
|---|---|---|
| Female | White | Married |

6-DATE OF BIRTH. Nov (Month) 2 (Day), 1889 (Year)

| 7-AGE. | If LESS than 1 day, |
|---|---|
| 37 yrs. 4 mos. 0 ds. | ....hrs. or....min. |

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... housewife
(b) General nature of Industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE. (State or Country). Florida

PARENTS.

10-NAME OF FATHER. unknown

11-BIRTHPLACE OF FATHER. (State or Country). unknown

12-MAIDEN NAME OF MOTHER. unknown

13-BIRTHPLACE OF MOTHER. (State or Country). unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm T. Gunnavan

(Address) 401 Principio Place

15-

Filed ..... C. HAMPSON JONES, M. D. Registrar.

1927 For ..... A.C.H.

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. March (Month) 2 (Day) 1927 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

.....

.....

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

.....(Duration).....yrs.....mos.....ds.

(Signed) ..... M. D.
(Coroner.)

3/3 1927 (Address) 7632 Roland Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

| 19-PLACE OF BURIAL OR REMOVAL. | DATE OF BURIAL. |
|---|---|
| St. Marys Hampden | March 5 1927 |
| 20-UNDERTAKER. | ADDRESS. |
| Chenowet Dodson | 3615 Chestnut |

19656

# HEALTH DEPARTMENT—CITY OF BALTIMORE E 19656

## CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2828 Huntingdon ave St. 12-59 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jennie Smith

(Residence in Baltimore: No. 2828 Huntingdon ave St.; yrs. 59 mos. ..... ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. white

5-~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~. (Write the word.) Widow

6-DATE OF BIRTH. July 25 1868
(Month) (Day) (Year)

7-AGE. 59 yrs. 7 mos. 7 ds.

If LESS than 1 day, ....hrs. or.... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). md

PARENTS.

10-NAME OF FATHER. unknown

11-BIRTHPLACE OF FATHER, (State or Country). unknown

12-MAIDEN NAME OF MOTHER. unknown

13-BIRTHPLACE OF MOTHER, (State or Country). unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Smith

(Address) 2828 Huntingdon Ave

15-

Filed. ..... 1927 C. HAMPSON JONES, M. D. Registrar.

Page 2844

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. March 2 192 7
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of Heart

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John H. Morrison M. D.
(Coroner)

3/3 192 7 (Address) 1692 Rolandave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

| 19-PLACE OF BURIAL OR REMOVAL. | DATE OF BURIAL. |
|---|---|
| Lorraine Park Cem | March 5 19 27 |
| 20-UNDERTAKER. Chenowith Son | ADDRESS 3615 Chestnut ave |

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19657

## CERTIFICATE OF DEATH.

101-601 E 19657

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 728 E Preston St. 9-18 WARD)

2-FULL NAME George C Jones

(a) RESIDENCE NO. 728 E Preston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 4 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Ida M Jones

6 DATE OF BIRTH (month, day, and year) Oct 26th 1858

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 68 | 4 | 5 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) ~~Baltimore~~ 030

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Christopher Jones

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Snowden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mrs Ida M. Jones

(Address) 728 E Preston St

15 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 3rd 1927

17 I HEREBY CERTIFY, That I attended deceased from 2/21, 1927, to 3/3, 1927.

that I last saw him alive on 3/3, 1927,

and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Leonard E Beach, M. D.

. 19 (Address) 2229 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL Mar 7th 1927

20 UNDERTAKER George Schilling & Sons — ADDRESS 1126 E Monument St

Spec.-7-17-26—A Co.—200 Bks.

E 19658

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100 E 19658

## CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 808 Resivoir St St. 13-59 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Morris Levy

(a) RESIDENCE NO. 808 Resivoir St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dora Levy

6 DATE OF BIRTH (month, day, and year) Sept 8/1850

| 7 AGE | Years | Months | Days | If LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 76 | 5 | 23 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Grodno Russia

(State or country)

PARENTS

10 NAME OF FATHER Cornelius Levy

11 BIRTHPLACE OF FATHER (City or town) Russia

(State or country)

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (City or town) Russia

(State or country)

14 Informant Madeline Levy

(Address) 808 Resivoir St.

15 Filed - 1927 Per C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3/27 19

17 I HEREBY CERTIFY, That I attended deceased from Febr 5, 1927, to March 3, 1927,

that I last saw h[illegible] alive on March 3, 1927,

and that death occurred, on the date stated above, at 11.20 p. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. M. Levy, M. D.

Died 3/27 19 (Address) 1123 Dolphin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cemetery Date of Burial March 4/27

20 UNDERTAKER J. Ahrens & Co ADDRESS 331 Fulton Ave

Very important. See instructions on back

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19659

## CERTIFICATE OF DEATH

E 19659

REGISTERED NO. 101-901 / 1927

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4525 Allington Av ST., Lauraville (WARD) 7th

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo. H. Conner

(a) RESIDENCE NO. 4525 Allington Av ST.; ..... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Martha Conner

6 DATE OF BIRTH (month, day, and year) Aug 31: 1843

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 83 | 6 | 1 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Port Deposite, Md

PARENTS

10 NAME OF FATHER: Geo. H. Conner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Port Deposite, Md.

12 MAIDEN NAME OF MOTHER: Rebecca Stevens

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Port Deposite, Md.

14 Informant: Louis Conner (Address) 4525 Arlington Av

15 Filed ... 1927 ... C. HAMPSON JONES, M. D. Registrar

Per ...

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 2nd 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 15, 1927, to March 2, 1927, that I last saw him alive on March 2, 1927, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

Toxemia. (duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary) Erysipeloid (duration) ... yrs. ... mos. 10 ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Elmer S Webster, M. D.

, 1927 (Address) 703 Belair Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Port Deposite, Md. | Mar 4 1927 |
| 20 UNDERTAKER | ADDRESS |
| F. B. Kefplant | 150 N Ballo St |

Spec. -7-17-26—A Co.—200 Bks.

E 19660 1926

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19660

## CERTIFICATE OF DEATH

129 1890 36

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 1350 Whatcoat St., 15-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nettie Washington

(a) RESIDENCE NO. 1350 Whatcoat St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 94 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 1890

7 AGE: Years 36 Months 11 Days — IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer): 041

(c) Name of employer: General

9 BIRTHPLACE (city or town): City

(State or country)

PARENTS

10 NAME OF FATHER: Chas Washington

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Virginia

12 MAIDEN NAME OF MOTHER: Ida Johnson

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Md

14 Informant: Laura Washington

(Address) 1374 Whatcoat St

15 Filed APR 4 - 1927 C. HAMILTON JONES, M. D. Registrar

Per R K

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 2nd 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 17th 1927 to Mar 2nd 1927

that I last saw her alive on Mar 2nd 1927

and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Aortic Stenosis & Heart

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary): Interstitial Nephritis

(duration) yrs. mos. ds. not known

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Harry T Brown M. D.

3/24/1927 (Address) 1916 Penna ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Lebanon — Date of Burial Mar 4th 1927

20 UNDERTAKER: Emmett E Wright — ADDRESS 1611 Penna ave

Spec—12-23-21—E.B.R.S.—400 Bks.

Lomax

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19661

## CERTIFICATE OF DEATH.

E 19661

1-PLACE OF DEATH 325 N. Gilmor St. 19-27 Registered No. 161-001

City of BALTIMORE: (No. ~~208~~ 325 N. Gilmor St. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Lomax

(a) Residence No. 325 N. Gilmor St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX male | 4-COLOR OR RACE, colored | 5-Single, Married, Widowed, or Divorced, (Write the word.) Infant

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Feb 25, 1927

7-AGE, 5 yrs. mos. ds. | If LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) Pikesville Md.
(State or Country),

PARENTS.

10-NAME OF FATHER, John Lomax

11-BIRTHPLACE OF FATHER (city or town) S. C.
(State or Country),

12-MAIDEN NAME OF MOTHER, Mattie Lomax

13-BIRTHPLACE OF MOTHER (city or town) S. C.
(State or Country),

14-INFORMANT Adelia Harrison
(Address) 232 N. Gilmor St.

15-FILED 1927 HAMPSON JONES, M. D. Registrar.
PAR R/L

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 3-2-27

17- I HEREBY CERTIFY, That I attended deceased from 2-25-27, 19..., to 3-2-27, 19..., that I last saw her alive on 3-2-27, 19..., and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Asthenia Neonatorum
(Premature baby)
(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. M. Williams, M. D.
3-2, 19 27 (Address) 1830 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem. | DATE OF BURIAL 3-4-27

20-UNDERTAKER Samuel H. Hemsley | ADDRESS 578 Pa Ave

spec.—1-12-23—M&T—500 Blks.

20 395 E 19662

# HEALTH DEPARTMENT—CITY OF BALTIMORE E 19662

## CERTIFICATE OF DEATH.

32 Pearl V. Martin

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 9-46 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pearl Martin

(a) RESIDENCE NO 2828 Montebello Ave Balto. - Md WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year) Feb 23 - 1914

8 AGE — Years: 13 — Months: — Days: 7 — If LESS than 1 day, hrs or min: 9

9 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Scholar
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

10 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

11 NAME OF FATHER: Garland Martin

12 BIRTHPLACE OF FATHER (city or town) (State or country): West Va

13 MAIDEN NAME OF MOTHER: Mary Damster

14 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Parents
(Address) JOHNS HOPKINS HOSPITAL

15 Filed 4-1927, 19 C. HAMPTON JONES, M. D. Registrar
Per RK

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 2 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 28, 1927, to Mar. 2, 1927, that I last saw her alive on Mar 2, 1927 and that death occurred, on the date stated above, at 12 30 pm

The CAUSE OF DEATH* was as follows:

~~acute chorea~~
Meningitis, Tuberculous

(duration) yrs 1 mos ds.

CONTRIBUTORY (Secondary) Acute chorea

(duration) yrs 1/2 mos. ds.

18 Where was disease contracted if not at place of death? 2828 Montebello Ave

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Spinal fluid

(Signed) H. E. Handler, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: Mar 5 1927

UNDERTAKER: A. B. Marshall — ADDRESS: 3539 Falls Road

Spec.—6-9-19—H. P. Co.—1000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19663

## CERTIFICATE OF DEATH.

11-002 E 19663

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 709 W 33rd St (ST.) 13-51 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. John Hanes.

(a) RESIDENCE. No. 709 W 33 ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jno Hanes

6 DATE OF BIRTH (month, day, and year): Sept. 1853

7 AGE: Years 73 | Months 11 mos | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer): do
(c) Name of employer: Gorsuch Bro.

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Helen W Seitz
(Address) 709 W 33rd St

15 Filed MAR 4 - 1927. C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) MAR. 1 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb- 24 1927 to Feb 28 1927.
that I last saw h him alive on Feb. 28 1927.
and that death occurred, on the date stated above, at 6 30 A. m.

The CAUSE OF DEATH* was as follows:
Myocarditis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): Grippe (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) C. J. Davies, M. D.

3-2-1927 (Address) 800 W 33rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Hampden — DATE OF BURIAL: March 4 '27

20 UNDERTAKER: Franklin W Seitz — ADDRESS: 709 W 33 St

Spec.—1-10-21—M&T—1500 Bks.

Geagan

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19664

## CERTIFICATE OF DEATH.

E 19664

1-PLACE OF DEATH Asquith & Ashland Ave

CITY OF BALTIMORE: (No. Motherhouse of Notre Dame ST., WARD) 10-14

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Lambertin Geagan

(a) RESIDENCE NO. Asquith St. & Ashland Ave ST., WARD Camden New Jersey.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 9 1861

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 66 | 1 | 22 24 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher 068

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Luke Geagan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Clapland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant (Address) Sister Superior Notre Dame Asquith St City

15 Filed MAR 4 1927 19 C. HAMPTON JONES, M. D. Registrar Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct. 25, 1926, to March 3, 1927,

that I last saw her alive on March 3, 1927,

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Usual signs

(Signed) J. J. Kirby, M. D.

3/3, 1927 (Address) 110 E Hoffman Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Natch Cliff Md DATE OF BURIAL March 5 1927

20 UNDERTAKER Frank A. Leach ADDRESS 910 N Gay

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19665

## CERTIFICATE OF DEATH.

123 E 19665

1-PLACE OF DEATH Maryland General Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 1 ST. 16 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia Guth

(a) RESIDENCE NO. 703 N. Monroe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm R Guth

6 DATE OF BIRTH (month, day, and year) Sept 23, 1860

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 66 | 3 | 8 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Joseph S. Knoll

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER /

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Daughter (Address) 703 N. Monroe St

15 Filed MAR 4 - 1927 Registrar C. HAMPSON JONES, M. D. Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 1st 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 27, 1927, to Mar 1, 1927, that I last saw her alive on Mar 1st, 1927, and that death occurred, on the date stated above, at 6 20 P m.

The CAUSE OF DEATH* was as follows:

Cholecystitis

Cholelithiasis

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. C. Zimmerman, M. D.

, 19 (Address) Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery DATE OF BURIAL 3/4/1927

20 UNDERTAKER Chas Weber & Son ADDRESS 2503 Edmondson Ave

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19666

90 E 19666

## CERTIFICATE OF DEATH.

REGISTERED NO. 13-59

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2101 Broadfield ave ~~ST~~ WARD)

2-FULL NAME William Fisher

(a) RESIDENCE NO. 2101 Broadfield ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | married |

a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophia Fisher

DATE OF BIRTH (month, day, and year) 1861

| AGE | Years | Months | Days | If LESS than 1 day, hrs or min |
|---|---|---|---|---|
| 60 years | ~~1861~~ | | | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real estate

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Minsk, Russia

PARENTS

10 NAME OF FATHER Jonas Fisher

11 BIRTHPLACE OF FATHER (city or town) Minsk Russia (State or country)

12 MAIDEN NAME OF MOTHER Faiga ?

13 BIRTHPLACE OF MOTHER (city or town) Russia (State or country)

14 Informant Rose Fisher (Address) 2101 Broadfield ave

15 Filed MAR 4 - 1927 By C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2 1927

17 I HEREBY CERTIFY, That I attended deceased from 1916, to March 2 1927, that I last saw him alive on March 2 1927, and that death occurred, on the date stated above, at 9 30 p m

The CAUSE OF DEATH* was as follows:

Bronchopneumonia + hypostatic congestion of lungs with edema.

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) myocarditis hypertension, C. S. arteriosclerosis (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Pulmonary consolidation

(Signed) Benjamin Rubinow, M. D.

3-3, 1927 (Address) 1804 Eutaw pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodmen Circle Glen

DATE OF BURIAL 3/4 1927

UNDERTAKER Jake Lewis ADDRESS 1939 E Baltimore

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19667

## CERTIFICATE OF DEATH.

101 001 E 19667

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2111 (ST.) Allendale Rd (WARD) 24 61

2-FULL NAME Joseph Gillet Allinson

(a) RESIDENCE NO. 2111 Allendale ST. Rd WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: E Allinson

6 DATE OF BIRTH (month, day, and year): June 1/1843

7 AGE: Years 83 | Months 9 | Days 2 | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Comm'l Salesman

(b) General nature of industry, business, or establishment in which employed (or employer): Shoes from 66

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): North Hadley Mass.

PARENTS

10 NAME OF FATHER: John Allinson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Emeline Sanford

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant (Address): Daughter 2111 Allendale Rd

15 Filed MAR 4 - 1927 C. HARRISON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 3 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1926, to Mch 3d, 1927, that I last saw him alive on Mch 2nd, 1927, and that death occurred, on the date stated above, at 9.45a m.

The CAUSE OF DEATH* was as follows:

Myocarditis — 1

Asthenia

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia type 1 11/20/26

duration yrs. mos.

18 Where was disease contracted if not at place of death?..... — apt

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Course

(Signed) Chas L Gardner M. D.

19 (Address) 3123 W North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oxmoor Va

DATE OF BURIAL: MAR 5 1927

20 UNDERTAKER: Geo W Little

ADDRESS: 3504 EDMONDSON AVE

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

19668

11-001

## CERTIFICATE OF DEATH

E 19668

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3910 Elsinmount Ave. 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Longobardo.

(a) RESIDENCE NO. 3910 Elsinmount Ave. 26 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? 11 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Rose Longobardo

6 DATE OF BIRTH (month, day, and year) Dec. 11th 1898

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 28 | 2 | 19 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tin Mill Employee

(b) General nature of industry, business, or establishment in which employed (or employer) Bethlehem Steel Co

(c) Name of employer

9 BIRTHPLACE (city or town) Italy.

(State or country)

PARENTS

10 NAME OF FATHER Frank Longobardo.

11 BIRTHPLACE OF FATHER (City or town) Italy.

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Italy.

(State or country)

14 Informant Anna Longobardo

(Address) 3910 Elsinmount ave

15 Filed 4-1927 C. HARRISON JONES, M. D. Registrar

By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2nd 1927

17 I HEREBY CERTIFY, That I attended deceased from 2-20, 1927, to March 2, 1927, that I last saw h[illegible] alive on March 2, 1927, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) C. Arrigoni, M. D.

, 19 (Address) 794 N Eden St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cemetery — Date of Burial March 7th 1927

20 UNDERTAKER Lilly & Zeiler — ADDRESS 4038 Wash Blvd

Spec.—1-10-21—M&T—1500 Bks.

Curlie

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19669

## CERTIFICATE OF DEATH.

E 19669

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Maryland General Hospital

CITY OF BALTIMORE: (No. 226 St Helena ave ST., 11-24 WARD)

2-FULL NAME Mrs. Grace Curlie

(a) RESIDENCE NO. St. Helena Md ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Vallie E. Curlie

6 DATE OF BIRTH (month, day, and year): June 1876

7 AGE: Years 50 | Months 7 8 | Days 20 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Hartford Co. Md

PARENTS

10 NAME OF FATHER: Geo. L. Baston

11 BIRTHPLACE OF FATHER (city or town) (State or country): Hartford Co. Md

12 MAIDEN NAME OF MOTHER: Margaret Glackin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Cecil Co Md

14 Informant: Vallie E. Curlie (Address) 226 St Helena ave

15 Filed APR 4 - 1927 HAMILTON JONES, M. D. Registrar

Per Lyc.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 28 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 27, 1927, to Feb 28, 1927, that I last saw her alive on Feb 28, 1927, and that death occurred, on the date stated above, at 5.25 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Cholecystitis

Cholelithiasis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation (duration) yrs. mos. 5 min ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? yes Date of 1-25-27 Removal of gall Bladder

Was there an autopsy? no

What test confirmed diagnosis? Clinical ?

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem. DATE OF BURIAL: Mch 4th 1927

20 UNDERTAKER: Lilly & Zeiler Co. ADDRESS: 403 So. Wolfe St

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19670

## CERTIFICATE OF DEATH.

3-27 181-001

E 19670

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Weber

(a) RESIDENCE NO. 4025 Eastern Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | white | widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late George Weber

6 DATE OF BIRTH (month, day, and year) July 8/1845

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| 81 | 82 | 7 | 23 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Christian Weise

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara ------

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Daniel Weber (sin)

(Address) Middle River Md.

15 Filed MAR 4 - 1927 C. HAMPTON JONES, M. D. Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 Mar 3/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Illuminating Gas Poisoning-accid-ent -al, Feb 24/27.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia - Chr. Nephritis (duration) yrs. mos. 3 ds.

(Signed) J. H. Potter M. D.

(Coroner)

3/4/27 19 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cent. Date of Burial Mar 6 1927

20 UNDERTAKER Lilly & Zeiler Co ADDRESS 1031 W Balto St

Spec.—12-9-25—A Co.—200 Bks.

Jane C Savage.

HEALTH DEPARTMENT, CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 E 19671

E 19671

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 530 N Gilmor St. 19-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane C Savage

(a) RESIDENCE NO. 530 N Gilmor St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: C

5 Single, Married, Widowed, or Divorced, (write the word): Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Savage.

6 DATE OF BIRTH (month, day, and year) March 20th 1872

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 55 | 7 | 7 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: unemployed

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Ct Murray Co Md

PARENTS

10 NAME OF FATHER Jelson Savage

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ct Murray Co

14 Informant Jesse Masters

(Address) 530 N. Gilmor

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

March 2d 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb 26 19 27, to Mch 2 19 27, that I last saw h[illegible] alive on March 1st 19 27, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Carcinomata Uteri

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? City Hospital

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Microscopic exam

(Signed) Watts Jones, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn cemetery — Date of Burial: Mar 14 1927

20 UNDERTAKER: Wm Geo N. Dennis & Co T. E. Kelson — ADDRESS: 1303 Eastman St

APR 1 1927

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 19672

101-001

E 19672

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 602 School St. 15-21 Ward)

2-FULL NAME William Johnson

(a) RESIDENCE NO. 602 School St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | Married |

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Lena Johnson

6 DATE OF BIRTH (month, day, and year) Oct 15 1888

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 38 | 4 | 16/17 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) Richmond Co

(State or country) Va.

PARENTS

10 NAME OF FATHER Shadrick Johnson

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Va.

12 MAIDEN NAME OF MOTHER Lucy Boyd

13 BIRTHPLACE OF MOTHER (city or town) Va

(State or country)

14 Informant Lena Johnson

(Address) 503 Prestman St

15 Filed MAR 4 - 1927 HAWSON JONES, M.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 1 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 25, 1927, to Mar 1, 1927, that I last saw h[illegible] alive on Feb 28, 1927, and that death occurred, on the date stated above, at 2.45 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ____ yrs. ____ mos. 4 ds.

CONTRIBUTORY (Secondary) _____

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted

If not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) C W Elam Jr, M. D.

3/1, 1927 (Address) 1928 Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Sharpsburg Richmond Co Va. | March 4 1927 |
| 20 UNDERTAKER | ADDRESS |
| Mrs James H. Dennis per. J E. Kelson | 1303 Prestman St |

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 19673

REGISTERED NO. 22-002 E 19673

1-PLACE OF DEATH

City of BALTIMORE: (No. 4840 Park Heights Ave St. 27-6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fred I King

(a) RESIDENCE NO. 4840 Park Heights Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marie F King

6 DATE OF BIRTH (month, day, and year) Jan 25 1879

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|---|
| | 48 | 1 | 7 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steward

(b) General nature of industry, business, or establishment in which employed (or employer) Club

(c) Name of employer Moose Club

9 BIRTHPLACE (city or town) Balto

(State or country) Md

PARENTS

10 NAME OF FATHER Fred I King

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Lena Heinichs

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto Md

14 Informant Jno. B. King

(Address) 4840 Park Heights Ave

15 Filed ....., 19 ..... Registrar

Per HAMPSON JONES, M. D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 2 1927

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1927, to Nov. 2, 1927, that I last saw h[illegible] alive on Nov 1 1927, and that death occurred, on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) 4 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

, 19 (Address) 1340 Eutaw

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — Date of Burial Nov 4 1927

20 UNDERTAKER H. M. Cook — ADDRESS 302 E Madison

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19674

## CERTIFICATE OF DEATH.

E 19674

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Md Sol Hospital St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Benjamin F. Dingley

(a) RESIDENCE NO. Kelly Station St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Cecelia Dingley

6 DATE OF BIRTH (month, day, and year) Aug. 29-1863

7 AGE — Years: 53 — Months: 6 — Days: 3 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): Stanley

(c) Name of employer: Construction Co

9 BIRTHPLACE (city or town) _____

(State or country) New York

PARENTS

10 NAME OF FATHER Benjamin Dingley

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Maine

12 MAIDEN NAME OF MOTHER Mary Crane

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Ireland

14 Informant Robert Dingley

(Address) Kelly's Station Md & Co

15 Filed APR 4 - 1927 C. HARRY JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2-27 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull

Accidental

(duration) .....yrs. .....mos. 2 ds.

CONTRIBUTORY (Secondary) Struck by Lever plank

(duration) .....yrs. .....mos. .....ds.

(Signed) J. F. Hennessey M. D.

(Coroner)

March 25 1927 (Address) 2502 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Md Holy Cross, Md County — Date of Burial: March 1927

20 UNDERTAKER William Cook — ADDRESS 502 E Wash Ave

pec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19675

## CERTIFICATE OF DEATH.

11-15

129 E 19675

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1007 N. Calvert ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Stewart Ridgely

(a) RESIDENCE NO. 1007 N. Calvert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

6 If married, widowed, or divorced (or) WIFE of: Otho E. Ridgely

7 DATE OF BIRTH (month, day, and year): March 22nd 1853

8 AGE — Years: 73 — Months: 11 — Days: 10 — If LESS than 1 day, ... hrs. or ... min.

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer:

10 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Capt. Charles J. Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country): Easton Md

12 MAIDEN NAME OF MOTHER: Maria R. Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Otho E. Ridgely Jr.

(Address)

15 Filed ... 19... Registrar

C. HAMILTON JONES, M. D.

84-1521

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 2 1927

17 I HEREBY CERTIFY, That I attended deceased from May, 1920, to March 1, 1927, that I last saw h[illegible] alive on March 1, 1927, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Chronic Osteo-Arthritis.

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pyelitis & Nephritis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1007 N Calvert St.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Urine.

(Signed) A. O. Atkinson, M. D.

, 19 (Address) 1010 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loraine Cem

DATE OF BURIAL: March 19 27

20 UNDERTAKER: Henry Watkins Sons

ADDRESS: Baltimore

pec.—1-12-23—M&T—500 Blks.

E 19676

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19676

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) West Balto Gen. Hospital (ST.) (WARD)

2-FULL NAME Edward Joseph Hibberd

(a) RESIDENCE NO. 1534 John ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Feb 22nd 1847

7 DATE OF BIRTH (month, day, and year): ~~Nov. 8, 1846~~

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 80 | | 11 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: John E. Hibberd

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Mary Roberts

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant (Address): John K. Shaw Catonsville Balto Co. Md

15 MAR 4 - 1927 CHARLES R. JONES, M.D. Registrar Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 3 1927.

17 I HEREBY CERTIFY, That I attended deceased from Feb 3 1927. to Mar 3 1927.

that I last saw living on Mar 3 1927.

and that death occurred, on the date stated above, at 9:20 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Cardiac Insufficiency

With edema

Mitral Regurgitation

(duration) 5 1/2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin. Exam

(Signed) Louis T. Levy, M. D.

3/3 1927 (Address) W. Balto Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Friends Cem Harford Rd

DATE OF BURIAL: 3-4. 1927

20 UNDERTAKER: Henry W Jenkins Sons Co

ADDRESS: Edward McCulloh

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 19677 100-001 E 19677

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 321 W. Belvedere Ave. St.) 27 56 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Mae Jones

(a) RESIDENCE NO. 321 W. Belvedere Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): November 28, 1926

7 AGE — Years: xxx Months: 3 Days: 5 3

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Maryland

PARENTS

10 NAME OF FATHER James A. Jones,

11 BIRTHPLACE OF FATHER (City or town) Chance (State or country) Maryland

12 MAIDEN NAME OF MOTHER Leola May Lainhart

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant James A. Jones

(Address) 321 W. Belvedere Avenue

15 Filed . 19 . Registrar

- 1927 C. HARRY JONES, M. D.

Par

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

March 3, 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 27, 1927, to Mar 3, 1927, that I last saw her alive on Mar 2, 1927, and that death occurred, on the date stated above, at 4.9 m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? usual clinical

(Signed) H. C. Humphreys, M. D.

3-3-27 (Address) 1002 W. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

Date of Burial: Mar. 4 1927

20 UNDERTAKER: Joseph S. Cook

ADDRESS 1003 Linden Ave

Spec.-7-17-26—A Co.—200 Bks.

E 19678

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

129 E 19678

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1802 E. Fairmount Ave. St. 64 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie Wagner

(a) RESIDENCE NO. 1802 E. Fairmount Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. da. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. da.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: ~~Color~~ White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Daniel Wagner

6 DATE OF BIRTH (month, day, and year): December 6, 1851

7 AGE: Years 75 Months 2 Days 26 24

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(r) Name of employer

9 BIRTHPLACE (city or town): Brooklyn

(State or country): New York

PARENTS

10 NAME OF FATHER: Lewis Fisher

11 BIRTHPLACE OF FATHER (City or town):

(State or country): New York,

12 MAIDEN NAME OF MOTHER: Letitia Everson

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): New York

14 Informant: Mrs. Edna Jacobs

(Address): 1927 Gough St.

15 Filed MAR 4 - 1927 G. HAMPSON JONES, M. D. Registrar

Per RK

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Mar. 2, 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 15 1927 to Mar 2 1927

that I last saw her alive on Feb. 28 1927

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

7

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Acute myocarditis

(duration) yrs. mos. 3 days

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Physical Signs

(Signed) [illegible], M. D.

3-2 1927 (Address) 1927 Gough St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bivalve, Wycomico Co., Md.

Date of Burial: Mar. 5 1927

20 UNDERTAKER: Joseph [illegible]

ADDRESS: No. 3 [illegible] St

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19679

## CERTIFICATE OF DEATH.

119 E 19679

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1 West Balto (Street) (WARD) 15-68

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Max Steierman

(a) RESIDENCE No. 1127 Fulleood ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widowed |

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Lola Esther

DATE OF BIRTH (month, day, and year) Jan 21, 1845

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| 82 | | 1 | 12 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Abel Steierman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Annie Schwartz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Hospital Records

(Address)

15 Filed 1927 C. HAMPSON JONES, M. D., Registrar

Per RK

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/3 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 5 1927 to Mar 3 1927

that I last saw living on Mar 3 1927

and that death occurred, on the date stated above, at 10 20 A. m.

The CAUSE OF DEATH* was as follows:

Senile Arteriosclerosis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Clin. Exam.

What test confirmed diagnosis?

(Signed) Louis T. Lavy M. D.

3/3 1927 (Address) W. Balto Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL March 4 1927

20 UNDERTAKER Sol Levinson & Bro — ADDRESS 1127 E Balto St

Spec—12-23-21—E.B.R.S.—400 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19680

## CERTIFICATE OF DEATH.

36-904 E 19680

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3335 Edmondson Ave St., 70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Preston Mason

(a) Residence No. 3335 Edmondson Ave St., Ward

(Usual place of abode)

(If non-resident give city or town and state)

Length of residence in city or town where death occurred yrs. 33 mos. 3 ds. 7 How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, ~~Married, Widowed,~~ or ~~Divorced~~ (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb 29, 1893

7-AGE. 33 yrs. 3 mos. 7 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Mineral Expert

(b) General nature of industry, business, or establishment in which employed (or employer). 009

(c) Name of employer.

9-BIRTHPLACE (city or town). (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Charles Grey Mason

11-BIRTHPLACE OF FATHER (city or town). (State or Country). Dudley Co. Va.

12-MAIDEN NAME OF MOTHER. Edith Emma Cook

13-BIRTHPLACE OF MOTHER (city or town). (State or Country). Essex Va.

14- (Informant) Irving L. Rice

(Address) 3335 Edmondson Ave

15- Filed. 1927 G. HAMPSON JONES, M. Registrar.

For Koffel

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 3, 1927

17- I HEREBY CERTIFY, That I attended deceased from Feb 24, 1927 to March 3, 1927.

that I last saw him alive on March 2, 1927

and that death occurred, on the date stated above, at 10:25 P.M.

The CAUSE OF DEATH* was as follows:

I. P. Nephritis & Cystitis.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Do not know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Urine

(Signed) J. C. Kelly M. D.

, 19 (Address) 3511 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19-PLACE OF BURIAL, CREMATION OR REMOVAL. | DATE OF BURIAL. |
|---|---|
| Woodlawn Cem | March 5, 1927 |
| 20-UNDERTAKER. George J. Smith | ADDRESS 153 Collins Ave |

Spec.—12-9-25—A Co.—200 Bks.

E 19681

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129 E 19681

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 400 N. Fulton Ave St. 20-27 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Charlotte Price

(a) RESIDENCE NO. Home for the Aged of the M E. Church St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. dys. How long in U. S., if of foreign birth? —yrs. — mos. — ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feby 17-1842

7 AGE: Years 85 | Months — | Days 15 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired housekeeper

(b) General nature of Industry, business, or establishment in which employed (or employer): Home

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Wm. Bockemiller

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore Co. Md.

12 MAIDEN NAME OF MOTHER Sarah Rawlings

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Anne Arundel Co Md.

14 Informant Etta Sunday

(Address) 400 Fulton Ave

15 Filed MAR 4 - 1927 19 C. HAMPSON JONES, M. D. Registrar

Per DK

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2- 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Febry 14 1927, to Mar 2, 1927, that I last saw h[er] alive on March 1, 1927, and that death occurred, on the date stated above, at 1.30 a m.

The CAUSE OF DEATH* was as follows:

Nephritis Chronic

(duration) 4 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Bronchitis Acute

(duration) — yrs. — mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Usual clinical methods

(Signed) George L. Shannon, M. D.

3/2, 1927 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem — Date of Burial: Mar 4 1927

20 UNDERTAKER: George J Smith — ADDRESS 153 [illegible] Hollins

Spec.–7-17-26—A Co.—200 Bks.

E 19682

# HEALTH DEPARTMENT—CITY OF BALTIMORE

11-001 E 19682

## CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 517 St Georges Road St. Ten Hills Ward 28-71

2-FULL NAME Sarah Gamble Cassidy

(a) RESIDENCE NO. 517 St George's Road St. Ten Hills Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 16, 1837

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 89 | 4 | 17 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER David Gamble

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Dunn

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant W. E. Garrison

(Address) 517 St Georges Rd Ten Hills

15 Filed MAR 4 - 1927 HARRISON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 3/27 19

17 I HEREBY CERTIFY, That I attended deceased from Feb 22, 1927, to Mch 2, 1927, that I last saw h[illegible] alive on Mch 2, 1927, and that death occurred, on the date stated above, at 2a m.

The CAUSE OF DEATH* was as follows:

La Grippe

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos 5 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. Oliver Murray M. D.

Mch 4 1927 (Address) 1517 Edmondson Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Date of Burial Mar 5 1927

20 UNDERTAKER George I Smith ADDRESS 1532 Hollins St

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19683

## CERTIFICATE OF DEATH.

74-001

74 E 19683

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1420 Jefferson ST. 5-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Hazel

(a) RESIDENCE No. 1420 Jefferson ST., ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): married.

6a If married, widowed, or divorced (HUSBAND) of (or) WIFE of: Robert Hazel.

6b DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years 55 | Months | Days | If LESS than 1 day, ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer): ofd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Henry Thomas.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Hannt Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mrs Hazel. (Address) 1420 Jefferson

15 Filed APR 4 - 1927 T. WILSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-2- 1927

17 I HEREBY CERTIFY, That I attended deceased from 2-28-, 1927, to 3-2-, 1927, that I last saw her alive on 3-1-, 1927, and that death occurred, on the date stated above, at 12,15 A.m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) ..... yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) H. W. Langley, M. D.

, 19 (Address) 64 N. Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Ceno

UNDERTAKER: Byron Knight

DATE OF BURIAL: 3/4 1927

ADDRESS 1218 Pine & Lafayette

Spec.-7-17-26—A Co.—200 Bks.

E 19684

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 19684

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 3401 Eastern Ave St. 2b-37 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William L. Swayze

(a) RESIDENCE NO. 3401 Eastern Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Swayze

6 DATE OF BIRTH (month, day, and year) Oct 22, 1855

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 71 | 4 | 6 11 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant 045

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 14 years

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) New Jersey

PARENTS

10 NAME OF FATHER Henry Swayze

11 BIRTHPLACE OF FATHER (City or town)

(State or country) New Jersey

12 MAIDEN NAME OF MOTHER Elizabeth Drake

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) New. Jersey

14 Informant Elizabeth Swayze

(Address) 3401 Eastern ave

15 Filed MAR 4 1927, 19 Hiram Jones, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3, 19 27

17 I HEREBY CERTIFY, That I attended deceased from Feb 14, 19 27, to March 3, 19 27

that I last saw h[illegible] alive on [illegible] 19 27

and that death occurred, on the data stated above, at 7 45 m.

The CAUSE OF DEATH* was as follows:

Valvular Heart

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) General Paralysis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Data of -

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) C. B. Neer, M. D.

3/4/27 (Address) 408 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Washington D. C. — Date of Burial: March 4 1927

20 UNDERTAKER: Henry Sander & Sons Inc — ADDRESS: 1710 Pe[illegible]

Spec.—12-9-25—A Co.—200 Bks.

E 19685

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19685

## CERTIFICATE OF DEATH.

REGISTERED NO. 93

1-PLACE OF DEATH Mercy Hospital

City of BALTIMORE: (No. 1 also known as 7-4 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Stamen also known as Ludwick Szabelski.

(a) RESIDENCE NO. 2023 Portugal St, St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Magia Szabelski

6 DATE OF BIRTH (month, day, and year): May 1878

7 AGE: Years 48 | Months 10 | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country) Poland

PARENTS

10 NAME OF FATHER — Szabelski

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Poland

12 MAIDEN NAME OF MOTHER Kirchcinski

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Poland

14 Informant Magia Szabelski

(Address) 2023 Portugal St

15 Filed 1927 19 C. HARRISON JONES, M. D. Registrar

16 Pat

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2 1927.

17 I HEREBY CERTIFY, That I attended deceased from Feb. 21, 1927, to March 2, 1927, that I last saw him alive on March 2, 1927, and that death occurred, on the date stated above, at 4.50 p.m.

The CAUSE OF DEATH* was as follows:

Acute Pancreatic Hemorrhagic Necrosis 72

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R. Motta, M. D.

March 2, 1927 (Address) Mercy Hospital Cit

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — Date of Burial: March 5, 1927

20 UNDERTAKER: J. W. Ozazewski — ADDRESS: 1930 Boston

Spec.—12-9-25—A Co.—200 Bks.

E 19686

# HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

E 19686

## CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1349 Sargeant St. 21-29 Ward)

2-FULL NAME Viola A. Mc Kenna

(a) RESIDENCE NO. 1349 Sargeant St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | white | married |

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. L. Mc Kenna

6 DATE OF BIRTH (month, day, and year) ~~December~~ November 1874

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| 53 | 52 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Wm. Robinson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Amanda Brodman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto Md

14 Informant Mrs Wm L. Mc Kenna

(Address) 1349 Sargeant St

15 Filed 4-1927 By H. HAMILTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-2-1927

17

I HEREBY CERTIFY, That I attended deceased from 3-2, 1927, to 3-2-, 1927, that I last saw h~~e~~ alive on 3-2-, 1927, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Indigestion

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Richard Dann, M. D.

, 19 (Address) 1 W Mt Royal

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem, Date of Burial March 5 1927

20 UNDERTAKER Tolen E Hawan & Son ADDRESS

Chas E Hawan 901 Hollins St

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19687

## CERTIFICATE OF DEATH

164

E 19687 REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1702 Holbrook St. 918 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah J. Byrne

(a) RESIDENCE NO. 1702 Holbrook St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. — mos. — ds. How long in U. S. if of foreign birth 37 yrs. — mos. — ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (Write the word) |
|---|---|---|
| Female | White | Single. |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Not Known

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min.. |
|---|---|---|---|---|
| About | 78 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Ireland

(State or country)

PARENTS

10 NAME OF FATHER Michael Byrne

11 BIRTHPLACE OF FATHER (City or town) Ireland.

(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Kelley

13 BIRTHPLACE OF MOTHER (city or town) Ireland.

(State or country)

14 Informant Mr. Michael Byrne

(Address) 1702 Holbrook St

15 Filed MAR 4 - 1927 C. HAMILTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3rd 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 22 1927 to Mar 3 1927.

that I last saw h... alive on Mar 3 1927.

and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Bernard Wess. M. D.

3/4. 1927 (Address) 914 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| New Cathedral Cemetery | March 7 1927 |

20 UNDERTAKER Henry Storck Son ADDRESS 1301 E Eager St

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19688 | CERTIFICATE OF DEATH. | 185 E 19688

1-PLACE OF DEATH

City of BALTIMORE: (No. 2302 Madison Ave Ward 13-59)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susie M Howard

(a) RESIDENCE NO. 2302 Madison Ave Ward

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | Colored | Widow |

5a If married, (widowed), or divorced HUSBAND of — (or) WIFE of Jesse Howard

6 DATE OF BIRTH (month, day, and year) 3-30 1869

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 57 56 | 11 | 21 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER unk

11 BIRTHPLACE OF FATHER (city or town) unk

(State or country)

12 MAIDEN NAME OF MOTHER unk

13 BIRTHPLACE OF MOTHER (city or town) unk

(State or country)

14 Informant Henry Howard

(Address) 2302 Madison Ave

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per Reed

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-2-1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 28, 1927, to Mar 2, 1927, that I last saw he alive on Mar 2, 1927, and that death occurred, on the date stated above, at 11 05 P m.

The CAUSE OF DEATH* was as follows:

(a) Pneumonia Lobar

(b) Bilateral —

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation of right over

(b) Consolidation (duration) yrs. mos. 3 ds.

18 Where was disease contracted (if not at place of death)? (a) Did an operation precede death? (a) Date of

Was there an autopsy? (a) What test confirmed diagnosis? Physical

(Signed) [illegible], M. D.

Mar. 1927 (Address) 502 Somerset

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery Date of Burial 3/6/1927

20 UNDERTAKER Mrs Lloyd G. Bailey ADDRESS 1421 Jefferson St

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001

E 19689

## CERTIFICATE OF DEATH.

E 19689

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 940 W Lexington St. 18-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Emily Eakinson

(a) RESIDENCE NO. 940 W Lexington St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Cau

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 2-22-27

7 AGE: Years | Months | Days: 5 4 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Carroll Johnson

11 BIRTHPLACE OF FATHER (city or town): Balto

(State or country)

12 MAIDEN NAME OF MOTHER Mary Johnson

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Va.

14 Informant

(Address)

15 Date 1927 C. HAMPSON JONES, M. D.

Registrar

Per

1105

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/3/27 1927

17

I HEREBY CERTIFY, That I attended deceased from 2-27 1927, to 3-3- 1927

that I last saw h-- alive on 3-2- 1927

and that death occurred, on the date stated above, at 7A m.

The CAUSE OF DEATH* was as follows: Congenital Atelectasis

Pneumatosis Cystoides

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

3/3, 1927 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial 19

20 UNDERTAKER

ADDRESS

JOHNS HOPKINS HOSPITAL

MAR 5 1927

Commissioner of Health

Per

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19690

## CERTIFICATE OF DEATH.

31 E 19690

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1018 Light ST., Ward 23-33

2-FULL NAME Charles Fortmann

(a) RESIDENCE NO. 1018 Light ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. — mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | White | Widower |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice A Fortmann

6 DATE OF BIRTH (month, day, and year) Feb. 22. 1882

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 45 | 0 | 9 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoe Operator

(b) General nature of industry, business, or establishment in which employed (or employer) Wm Bartlett & Co

(c) Name of employer Baltimore

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John H Fortmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Catherine Keller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mary A Meyer 1018 Light St

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1 1927

17 I HEREBY CERTIFY, That I attended deceased from March 24, 1926, to March 1, 1927, that I last saw him alive on March 1, 1927, and that death occurred, on the date stated above, at 9. P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 9 yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) G E Burton, M. D.

3/2, 1927 (Address) 301 E Conn St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross

DATE OF BURIAL 3-5 1927

20 UNDERTAKER Ehrlich Harle

ADDRESS 1158 W Fayette

spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19691

## CERTIFICATE OF DEATH.

101-001

101 E 19691

1-PLACE OF DEATH St Joseph. Hospital

CITY OF BALTIMORE: (No. Caroline & Aliceanna St. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Osel

(a) RESIDENCE NO. 428 E. Randall ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | white | W Dower |

a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Osel

DATE OF BIRTH (month, day, and year) Sept 5 1865

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 61 | 5 | 29 | |

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron worker Ret

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Hospital Record.

(Address)

15 Filed 1927 19 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1927

17

I HEREBY CERTIFY, That I attended deceased from March 1 1927 to March 4 1927.

that I last saw him alive on March 4 1927,

and that death occurred, on the date stated above, at 5.25 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? no Date of no.

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) Frank R DeSauler, M. D.

19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross

DATE OF BURIAL 8-7 1927

20 UNDERTAKER E & B Harla

ADDRESS 11[illegible] E Ward St

Spec.—1-10-21—M&T—1500 Bks.

# E 19692 HEALTH DEPARTMENT—CITY OF BALTIMORE E 19692

## CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7 Rosemont Avenue Raspebur ST. 27 WARD)

2-FULL NAME William J. Scholtholt

(a) RESIDENCE NO. 7 Rosemont Avenue Raspeburg, ST., 27 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bernadine M. Scholtholt

6 DATE OF BIRTH (month, day, and year) April 9, 1857

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 69 | 10 | 24 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker

003

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer Schmidt Bakery

9 BIRTHPLACE (city or town) (State or country) Raesfeld Germany

PARENTS

10 NAME OF FATHER John Scholtholt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mrs. Bernadine Scholtholt 7 Rosemont Ave. Raspe., Md.

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 3, 1927

17 I HEREBY CERTIFY, That I attended deceased from December 11, 1926, to March 3, 1927, that I last saw h in alive on March 3, 1927, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis; Arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. L. Williamson M. D.

R. M. Wilkinson

3/4/, 1927 (Address) Raspeburg, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Holy Redeemer Cemetery | March 7 1927 |
| 20 UNDERTAKER | ADDRESS |
| Fred Lassiter & Sons | Fullerton |

Spec.-1-10-21—M&T—1500 Bks.

19693 HEALTH DEPARTMENT—CITY OF BALTIMORE 19693

CERTIFICATE OF DEATH.

REGISTERED NO. 24-80 Rochester

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) Gunter & Chestnut Ave ST. 76 (WARD) 41

2-FULL NAME Mary Gunter

(a) RESIDENCE NO. Gunter & Chestnut Ave ST. WARD Rochester
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fem'l

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ind Gunter

6 DATE OF BIRTH (month, day, and year) Aug. 26th 1851

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 75 | 6 | 8 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Shrewsbery Pennsylvania

PARENTS

10 NAME OF FATHER Andrew Sadler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown Germany

12 MAIDEN NAME OF MOTHER Barbara Reis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown Germany

14 Informant Anna Frickey (Address) Gunther & Chestnut ave.

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/3/27

17 I HEREBY CERTIFY, That I attended deceased from Feby 22 1927 to Mar 3 1927

that I last saw h[illegible] alive on March 2 1927

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted (if not at place of death)?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm D Coppe M. D.

1927 (Address) Coppe & Souther

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery DATE OF BURIAL Mch 8 1927

20 UNDERTAKER Frederick Lasselman Son Fulberton ADDRESS

ree.—1-12-23—M&T—500 Bks.

E 19694

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19694

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bon Secours Hospital REGISTERED NO. 13-52-57

CITY OF BALTIMORE: (No. ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna E. Wallace

(a) RESIDENCE NO. 3515 Roland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

6 If married, widowed, or divorced HUSBAND of or) WIFE of —

DATE OF BIRTH (month, day, and year) January 17, 1874

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 53 ~~11~~ | 1 | 14 | |

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Edward Wallace

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Abbie Donohue

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Annie Shaffer

(Address) 7 Bel-Mar Gardens

15 Filed 1927, 19 C. HAMPSON JONES, M. D. Registrar

Par ACR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3 1927

17 I HEREBY CERTIFY, That I attended deceased from March. 2, 1927, to March 3, 1927, that I last saw her alive on March 3, 1927, and that death occurred, on the date stated above, at 3.30 A m.

The CAUSE OF DEATH* was as follows:

Acute Pancreatitis

Diabetic acidosis

A. Coroner J. Morrissey

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. ?. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical + autopsy

(Signed) Geo. D. Lipsey, M. D.

, 19 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peter's Cemetery — DATE OF BURIAL May. 5, 1927

20 UNDERTAKER E. LeRoy Stiffler — ADDRESS 125 E. Northern

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19695

E 19695

## CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3920 Claremount Ave ST. (or) WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Filomena Stassano

(a) RESIDENCE NO. 3920 Claremount Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Stassano

6 DATE OF BIRTH (month, day, and year) 10/15/1873.

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 53. | 4 | 16 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Rafael Moscato

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Mrs Petrelli

(Address) 3920 Claremount Ave

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/2/1927

17 I HEREBY CERTIFY, That I attended deceased from December, 1926, to March, 1927.

that I last saw h[illegible] alive on Feb. 24, 1927,

and that death occurred, on the date stated above, at 7.00 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach & Liver

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) R. S. Marr, M. D.

3.3 1927 (Address) 516 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus Cem — DATE OF BURIAL Mar 5 1927

20 UNDERTAKER John Ellis — ADDRESS 2108 Eutaw

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19696

## CERTIFICATE OF DEATH.

100-00

E 19696

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 233 S. Highland Ave Ward)

2-FULL NAME Louise C. Roth

(a) RESIDENCE NO. 233 S Highland Ave. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of single

6 DATE OF BIRTH (month, day, and year) Jan 6-1926

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 1 | 1 | 25 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER Joseph F. Roth

11 BIRTHPLACE OF FATHER (city or town) Balto.

(State or country) Md.

12 MAIDEN NAME OF MOTHER Elenora Elbert

13 BIRTHPLACE OF MOTHER (city or town) Balto.

(State or country) Md.

14 Informant Joseph F. Roth

(Address) 233 S. Highland ave

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per A.K.R.

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lob Bronchitis

Exhaustion (duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Measles (duration) yrs. mos. 2 ds.

March 4 1927 (Signed) G. C. Bradley M. D. (Corner)

(Address) 1431 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Hearts Cem Date of Burial Mar 5 1927

20 UNDERTAKER Lilly E Zeiler & Co ADDRESS 402 S Gilmor St

Spec.—7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19697

E 19697

## CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1901 West Lanvale St., 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth E. B. Wells

(a) RESIDENCE NO. 1901 West Lanvale St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE: 63 Years 62 Months Days

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Eastern Shore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Eastern Shore Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Eastern Shore Md

14 Informant Mrs Minnie M. H. Crawford

(Address) 712 Wyndhurst Ave

15 Filed 1927 By C. HARRISON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3rd 1927

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1927, to Mch 3, 1927, that I last saw h[illegible] alive on March 1, 1927, and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) 1 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

(Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

Date of Burial 3/5 1927

20 UNDERTAKER Wm Cook

ADDRESS 502 E Mt

Spec.–7-17-26—A Co.—200 Bks.

Dr Hyde 1109 E North Ave

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19698

## CERTIFICATE OF DEATH

90 E 19698

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1919 Kennedy Ave St., 9-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carleton D Engle

(a) RESIDENCE NO. 1919 Kennedy Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. 1 mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edith A. Engle

6 DATE OF BIRTH (month, day, and year) June 8, 1868

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..hrs. or ..min.. |
|---|---|---|---|---|
| | 58 | 8 | 26 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer U S Supt Reg'y

9 BIRTHPLACE (city or town)

(State or country) N. Ca

PARENTS

10 NAME OF FATHER James N. Engle

11 BIRTHPLACE OF FATHER (City or town)

(State or country) N. Ca

12 MAIDEN NAME OF MOTHER Margaret M Luke

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) N. Ca.

14 Informant Edith A Engle

(Address) 1919 Kennedy Ave

15 Filed 1927 By C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 25, 1927, to Mar 4, 1927, that I last saw h.. alive on Mar 4, 1927 and that death occurred, on the date stated above, at 10.40 a.m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

Influenza dilatation

(duration) 2 yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry Hyde, M. D.

3/4, 1927 (Address) 1100 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Mount Forest Md Mar 6 1927

20 UNDERTAKER — ADDRESS

W. E. Cook 501 E North Ave

Very Important. Not transferable.

Spec. 7-17-26—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19699

## CERTIFICATE OF DEATH

117 E·19699

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Wosk

(a) RESIDENCE NO. 13 S Ann St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. 8 mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | M |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julianne Wosh

6 DATE OF BIRTH (month, day, and year) June 16 1891

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|---|
| | 35 | 8 | 17 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of Industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Poland

PARENTS

10 NAME OF FATHER Andrew Wosh

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Julianne Wosh

(Address) 138 Ann

15 Filed - 1927 C. HAMPSON JONES, M. D. Registrar

Per RPB

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 Mar 3

17 I HEREBY CERTIFY, That I attended deceased from Feb 22, 1927, to Mar 3, 1927,

that I last saw him alive on Mar 3, 1927,

and that death occurred, on the date stated above, at 11 10 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (Post operative)

Ca E

(duration) yrs. mos. 1 da.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of 3/1/27

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) F. F. Lemley, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary

Date of Burial March 8 1927

20 UNDERTAKER Wendell Bryselton

ADDRESS 31 E Lanvale St

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E. 19700

## CERTIFICATE OF DEATH.

89 E 19700

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) 3903 Forest Park Ave St. 15-64 Ward)

2-FULL NAME William James Parker

(a) RESIDENCE NO. 3903 Forest Park Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 2 1876

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 50 | 10 | 2 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Secy
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer Judge Harlan Accomac Co

9 BIRTHPLACE (city or town)
(State or country) Va

PARENTS

10 NAME OF FATHER James H. Parker

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Anna Lee Parker

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Miss Lila Snyder
(Address) Forest Hill apts.

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Pat

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 4 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

angina pectoris 1a

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) no history

(duration) yrs. mos. ds.

(Signed) C. Hampson Jones M. D.
(Coroner)

Mar 5, 1927 (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death..... yrs., ..... mos., ..... ds. In the State yrs., ..... mos., ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Onancock Va — Date of Burial Mar 5 1927

20 UNDERTAKER W. M. Tuckner & Sons — ADDRESS Norfolk Va

ec.—1-12-23—M&T—500 Bks.

E 19701 HEALTH DEPARTMENT—CITY OF BALTIMORE E 19701

# CERTIFICATE OF DEATH.

90

REGISTERED NO. 16-68

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1212 Oakhurst Place ST. WARD)

2-FULL NAME Mary Ann Joppington

(a) RESIDENCE NO. 1212 Oakhurst Place WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | White | Widowed |

a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles F. Joppington

DATE OF BIRTH (month, day, and year) April 7 1848

| AGE | Years | Months | Days | If LESS than 1 day, hrs or min |
|---|---|---|---|---|
| | 78 | 10 | 4 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John B. Hallham

11 BIRTHPLACE OF FATHER (city or town) (State or country) a. a Co. Md

12 MAIDEN NAME OF MOTHER Eleanor Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Ina Shipley

(Address) 1212 Oakhurst Place

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

By

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3 1927

17 I HEREBY CERTIFY, That I attended deceased from January, 1926, to Mar. 3, 1927,

that I last saw her alive on Mar 2, 1927

and that death occurred, on the date stated above, at m

The CAUSE OF DEATH* was as follows:

Generalized Arterio sclerosis

many years duration yrs. mos ds.

CONTRIBUTORY (Secondary) Chr Myocardial insufficiency (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Carroll Lockard, M. D.

March 4, 1927 (Address) 4 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery

DATE OF BURIAL March 1927

20 UNDERTAKER Sta J Tessner & Sons

ADDRESS E Fa Ave

Spec.—12-9-25—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19702

## CERTIFICATE OF DEATH.

78 E 19702

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2719 Jefferson St. 6-10 Ward)

2-FULL NAME Dorothea E Ford.

(8) RESIDENCE NO. 2719 Jefferson St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 1- 1909

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 17 | 3 | 1 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Frederick A Ford
11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore Md
12 MAIDEN NAME OF MOTHER Odelia Reisinger
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Washington

14 Informant Odelia Reisinger
(Address) 2719 Jefferson St

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar
By _____

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 21 1927, to March 7, 1927,
that I last saw h[er] alive on March 7, 1927,
and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH* was as follows:

Acute cardiac dilatation 7 hrs.
(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) Epilepsy (grand mal)
(duration) 11 yrs. ___ mos. ___ ds.

18 Where was disease contracted _____
If not at place of death? _____
Did an operation precede death? no Date of _____
Was there an autopsy? no
What test confirmed diagnosis? _____
(Signed) L C Sobitsal M. D.
, 19 (Address) 447 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Louden Park Cem Date of Burial March 9 1927

20 UNDERTAKER Jno C Miller & Son ADDRESS 2334 Jefferson St

c.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

19703 / 31 E 19703

## CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1027 Warden St., 10-15 WARD)

2-FULL NAME Marguerite M. Barnes

(a) RESIDENCE NO. 1027 Warden ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. 8 mos. 14 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

6 If married, widowed, or divorced HUSBAND of (or) WIFE of William S. Barnes

DATE OF BIRTH (month, day, and year) Aug. 17, 1899

| AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 27 | 8 | 14 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Frederick Dewberry

11 BIRTHPLACE OF FATHER (city or town)
(State or country) England

12 MAIDEN NAME OF MOTHER Julie Dacey

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va.

14 Informant Frederick Dewberry
(Address) 1027 Warden Street

15 Filed 1927, 19 C. HAMPSON JONES, M. D.
For ..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5 1927

17 I HEREBY CERTIFY, That I attended deceased from March, 1927, to March 5, 1927, that I last saw h alive on March 5, 1927, and that death occurred, on the date stated above, at 2 ( m.

The CAUSE OF DEATH* was as follows:

Ch Pulmonary Tuberculosis

Absent (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pul Tuberculosis

Absent (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Dr

(Signed) C B Gamble Jr, M. D.

, 19 (Address) C B Gamble Jr

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: 3/7, 19 27

20 UNDERTAKER: Henry W. Mears

ADDRESS: 805 N. Calvert

Rec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19704 E 19704

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Josephs Hospital

CITY OF BALTIMORE: (No.) Caroline & Oliver ST. 9+11 (WARD)

2-FULL NAME John Fuhrman.

(a) RESIDENCE NO. Baker Ave. N. Putty Hill) ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 9 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | white | Single |

6 If married, widowed, or divorced HUSBAND of (or) WIFE of —

DATE OF BIRTH (month, day, and year) May 25-1906

| AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| 20 | [illegible] | 9 | 9 | |

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Craftsman

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Joseph F Fuhrman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Elizabeth Heltz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Joseph H. Fuhrman

(Address) Baker Ave N. Putty Hill

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

By ACH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1927

17 I HEREBY CERTIFY, That I attended deceased from March 3, 1927, to March 4, 1927

that I last saw him alive on March 4, 1927,

and that death occurred, on the date stated above, at 7:20 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? — Date of —

Was there an autopsy? None

What test confirmed diagnosis? Clinical.

(Signed) Frank P. Davidson, M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Holy Redeemer Cemetery | 3/7 1927 |
| 20 UNDERTAKER | ADDRESS |
| George J Ruth | 1733 Harford Ave |

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19705

## CERTIFICATE OF DEATH

100-68

E 19705

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1516 John St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George H. Perkinson

(a) RESIDENCE NO. 1516 John St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 25. 1926

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|---|
| | | 9 | 8 9 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none add

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER John P. Perkinson

11 BIRTHPLACE OF FATHER (City or town) Balto., Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mary E. Minner

13 BIRTHPLACE OF MOTHER (city or town) Balto., Md.
(State or country)

14 Informant J. P. Perkinson
(Address) 1516 John St.

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar
By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/4/27

17 I HEREBY CERTIFY, That I attended deceased from 3/3/27 to 3/4/27

that I last saw h... alive on 3/4/27

and that death occurred, on the date stated above, at 10.15 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) 1 day yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) History cold previous

(duration) yrs. mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? no

What test confirmed diagnosis? usual

(Signed) Bernard Tenny M. D.

3/4/1927 (Address) 910 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Peters Cem

Date of Burial March 5 1927

20 UNDERTAKER Margaret L. Flynn

ADDRESS 1412 Light

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19706

## CERTIFICATE OF DEATH.

21-31

31 ✓ E 19706

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals (T. L.) Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Pettiford

(a) RESIDENCE NO. 409 W. Hamburg st. St. Ward

(If usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Colored | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1910

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 17 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of indnstry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER Sam Peddiford

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Lou Rich

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant Hospital Records

(Address)

15 Filed 1927 19 Per C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from February 1, 1927, to March 1, 1927, that I last saw her alive on March 1, 1927, and that death occurred, on the date stated above, at 8.45 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Sputology

(Signed) W. E. Latchaw, M. D.

3-1-27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury cemetery Date of Burial mar 6 1927

20 UNDERTAKER Edward Bryan ADDRESS 631 Orleans st

Spec.—1-10-21—M&T—1500 Blks.

E 19707 HEALTH DEPARTMENT—CITY OF BALTIMORE 11-001 E 19707

# CERTIFICATE OF DEATH.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 217 N Spring St 5-8 WARD)

2-FULL NAME Stephen Kirby

(a) RESIDENCE NO. 217 N Spring St WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: Colored | 5 Single, Married, ~~Widowed~~, or Divorced, (write the word): Married

5a If married, widowed, or divorced
~~HUSBAND of~~ or) WIFE of Harriet Kirby

6 DATE OF BIRTH (month, day, and year) Mar 12 1861

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or ..... mins. |
|---|---|---|---|---|
| | 65 | 11 | 21 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Farm 040
(c) Name of employer Jenkins

9 BIRTHPLACE (city or town) (State or country) West River Maryland

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) West Rive
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Scott

13 BIRTHPLACE OF MOTHER (city or town) West Rive
(State or country) Maryland

14 Informant Eugene Cage
(Address) 17 N Bond St

15 Filed Mar 1927 19 C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 3, 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 1, 1927, to Mar 3, 1927, that I last saw h in alive on Mar 2, 1927, and that death occurred, on the date stated above, at 2 AM m.

The CAUSE OF DEATH* was as follows:
Broncho - Pneumonia.

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) La Grippe
(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Not known
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) R L Cosgrove, M. D.
, 19 (Address) 514 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stevens md

DATE OF BURIAL Mar 6 1927

20 UNDERTAKER Edward Bryan

ADDRESS 1681 Orleans St

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19708 | CERTIFICATE OF DEATH. | 129 E 19708

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. L St. 14-20 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Jenkins

(a) RESIDENCE NO. 1813 E. Madison St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Negro | Widowed |

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1857

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 70 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Caron Hooper

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant BALTIMORE CITY HOSPITALS

(Address) Records

1927 C. HAMPSON JONES, M. D.

Filed ..... 19 ..... Per ..... Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2 1927

17

I HEREBY CERTIFY, That I attended deceased from January 18, 1927, to March 2, 1927,

that I last saw her alive on March 1, 1927,

and that death occurred, on the date stated above, at 3:40 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Antemortem Sclerosis

Chronic Myocarditis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted

If not at place of death!

Did an operation precede death! no Date of

Was there an autopsy! yes

What test confirmed diagnosis! general & laboratory

(Signed) R. Hooper Lewis, M. D.

Mar 3, 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Asbury Cemetery | mar 5 1927 |
| 20 UNDERTAKER Edward Bryan | ADDRESS 1631 Orleans St |

Spec.—12-9-25—A Co.—200 Bks.

E 19709

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

3/E 19709

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. 21-24 B. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Peddiford

(a) RESIDENCE NO. 409 W. Hamburg st. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | S. |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1926

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 1 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ---

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary Peddiford

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed ....., 19 ..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from February 8, 1927, to March 2, 1927, that I last saw him alive on March 2, 1927, and that death occurred, on the date stated above, at 2.45 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous meningitis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) W.E. Cotton, M. D.

3-2-27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Asbury Cemetery | mar 6, 1927 |
| 20 UNDERTAKER Edward Bryan | ADDRESS 1651 Orleans st |

Mar 3 1927 B. Hammonds M.D.

ec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19710 — 101-001 — E 19710

## CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1713 w Franklin ST. 14-27 WARD)

2-FULL NAME Sophia A Freeman

(a) RESIDENCE NO. 1713 w Franklin ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 2 mos. 27 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Dec 5, 1924

| AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 2 | 2 | 28 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work no

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Perry Freeman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Gabby Cornish

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant (Address) Perry Freeman 1713 w Franklin st

15 Filed 3-5 1927 C. HAMPSON JONES, M. D. Registrar

Per .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2nd 1927

17 I HEREBY CERTIFY, That I attended deceased from March 2, 1927, to March ..., 19..., that I last saw her alive on March 2nd, 19..., and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Walter Johnson, M. D.

, 19 (Address) 634 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Mount Lion | 3/5 1927 |
| 20 UNDERTAKER Joseph A Lively. | ADDRESS 1098 W Mount St |

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19711

## CERTIFICATE OF DEATH

E 19711

1-PLACE OF DEATH

City of BALTIMORE: (No.) 2254 Brookfield (St.) (Ward) 59

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis A. Buschmann

(a) RESIDENCE NO. 2254 Brookfield ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 7 mos. 25 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | white | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna B. Buschmann

6 DATE OF BIRTH (month, day, and year) July 8 = 1854

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..hrs. or ..min.. |
|---|---|---|---|---|
| | 72 | 7 | 25 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Attorney at Law

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Francis Buschman

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Martha Baby

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs. Francis A. Buschmann

(Address) 2254 Brookfield ave

15 1927 C. HAMPSON JONES M. D.

Registrar

Per AKH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 2nd 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1. 1927 to Mar. 2. 1927

that I last saw he alive on Mar. 2, 1927

and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 5 ds.

18 Where was disease contracted

If not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Theodore Blake M. D.

3-3. 1927 (Address) 1014 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — Date of Burial 3/5/1927

20 UNDERTAKER Gus. Nebel & Son — ADDRESS 2503 Edmondson ave

Spec—12-23-21—E.B.R.S.—400 Eks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

19712 19712

## CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH 527 W Hamburg 21-21 Registered No.

City of BALTIMORE (No. 527 W Hamburg St., 21st Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo W Awalt

(a) Residence No. 527 W Hamburg St., 21 Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male | 4-COLOR OR RACE White | 5-CONDITION Married (Write the word)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Awalt

6-DATE OF BIRTH (month, day and year) Apr 9-1847

7-AGE 79 yrs. 9 mos. 25 ds. If LESS than 1 day ....hrs. or.....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Shoe Cutter
(b) General nature of industry, business, or establishment in which employed (or employer) 088
(c) Name of employer Baltimore Shoe

9-BIRTHPLACE (city or town) (State or Country) Germany

PARENTS

10-NAME OF FATHER Ferd Awalt
11-BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12-MAIDEN NAME OF MOTHER Elz Degas
13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14-INFORMANT Mrs. Awalt
(Address) 527 W Hamburg

15-Filed MAR 7 1927 By C. HAMPSON JONES, M. D. Registrar. Asst

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 4-27

17-I HEREBY CERTIFY, That I attended deceased from Jan 4 27 to Mch 4 27
that I last saw h[illegible] alive on Mch 3 27
and that death occurred, on the date stated above, at 12.40 p.m.

The CAUSE OF DEATH* was as follows: Chr Int. Nephr.

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What tests confirmed diagnosis? Clinical symptoms
(Signed) John F Schwarzenberg M.D.
19 (Address) 1 West Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park | DATE OF BURIAL, MAR 7 1927 19...

20-UNDERTAKER, Geo W Little | ADDRESS 4700 EDMONDSON AVE.

Spec.–7-17-26—A Co.—200 Bks.

E 19713

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

3/ E·19713

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1143 Stansbury St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert F Sloran.

(a) RESIDENCE NO. 1143 Stansbury St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. 7 mos. 10 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 24 1879

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..hrs. or ..min.. |
|---|---|---|---|---|
| | 47 | 7 | 10 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Richard F. Sloran

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Washington D.C.

12 MAIDEN NAME OF MOTHER Mary C Hubbard

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Md

14 Informant Mrs Charles E. Sullivan

(Address) 1143 Stansbury St

15 Filed ..., 19.. Registrar

C. HAMPSON JONES, M. D.

RPH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-4 1927

17 I HEREBY CERTIFY, That I attended deceased from 2-1-, 1927, to 3-4-, 1927,

that I last saw h— alive on 3-4-, 1927,

and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary TB

6 (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

3 (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Data of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Richard Dacey, M. D.

, 19 (Address) 1127 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Baltimore

Date of Burial MAR 7 1927 19

20 UNDERTAKER Geo F. Little

ADDRESS EDMONDSON AVE.

Spec.—1-10-21 M&T 1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19714

E 19714

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hopkins Hospital ST. 12-50 (WARD)

2-FULL NAME Mary B. Norton

(a) RESIDENCE NO. Hopkins Apartment ST., ..... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of widow of William J. Norton

6 DATE OF BIRTH (month, day, and year) Oct 24, 1849

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs or ....min. |
|---|---|---|---|---|
| | 77 | 4 | 8 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) ..... None

(c) Name of employer ..... None

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Thomas W. Jamison

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md

12 MAIDEN NAME OF MOTHER Julia A. Harper

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md

14 Informant ..... Eugene L. Norton

(Address) 420 Greenway

15 Filed ..... 1927 ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4th 1927

17 I HEREBY CERTIFY, That I attended deceased from March 2. 1927. to March 4th 1927. that I last saw h alive on March 4th 1927. and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

a. Cardiac Dilation

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Valv. Ind. Hypertension

(duration) unknown mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Hopkins Bruce M. D.

3/4 1927 (Address) 2844 St. Paul Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL March 5th 1927

20 UNDERTAKER Henry J. Jenkins & Son

ADDRESS Cathedral & Mt. Vernon Sts

Spec.—5-19-13—M. & T.—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

19715

## CERTIFICATE OF DEATH.

100 E 19715

REGISTERED NO. C 19-16

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1310 Mulberry St.; ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Irene Mills

(Residence in Baltimore: No. 1310 Mulberry St.; yrs., mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)

6-DATE OF BIRTH, Jan. 5th (Month) (Day), 1926 (Year)

7-AGE, 1 yrs. 1 mos. 27 ds. If LESS than 1 day, ....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ——
(b) General nature of industry, business, or establishment in which employed (or employer) ——

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Herbert Mills

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Sadie Chase

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sadie Mills

(Address) 1310 N. Mulberry St

15-

Filed ....., 191.....

C. HAMPSON JONES, M.D. Registrar.

3-1-1927

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 3 (Month) 2 (Day) 1927 (Year), 191...

17- I HEREBY CERTIFY, That I attended deceased from 2-21- 1927, to 3-2- 1927, that I saw h[illegible] alive on 3/2/27 191, and that death occurred, on the date stated above, at 5:30 Pm.

The CAUSE OF DEATH* was as follows:

(a) Lobar Pneumonia

(b)

(c)

(Duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary) Cold

(Duration) ... yrs. ... mos. 3 ds.

(Signed) M B Boyton M. D.

..., 191... (Address) 1618 Carlton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem DATE OF BURIAL, Mch 5 1927

20-UNDERTAKER A. E. Jones ADDRESS 111 S. Gilmor St

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19716

## CERTIFICATE OF DEATH.

90 E 19716

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St. 25-75 Ward)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lydia Phipps

(a) RESIDENCE NO Marshall's Court - Brooklyn Md St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1867?

| 7 AGE | Years | Months | Days | IF LESS than 1 day ...hrs. or ...min. |
|---|---|---|---|---|
| | 60? | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Jacob Phipps

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Elizabeth —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant BALTIMORE CITY HOSPITALS

(Address) Records

15 Filed ... 19 ... 14 ... ds.

C. HAMPSON JONES, M. D.

Registrar

1927 Per ...

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3 1927

17

I HEREBY CERTIFY, That I attended deceased from February 14 1927, to March 3, 1927, that I last saw him alive on March 3, 1927, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Arterial Sclerosis, Senility

Hypertension

Chronic Myocarditis & Insufficiency

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) ...yrs. ...mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? General & Laboratory

(Signed) R. Hooper Lamb, M. D.

Mar 31 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Cedar Hill Bur

Date of Burial

March 5 1927

20 UNDERTAKER

W. W. Routson

ADDRESS

Greene & Saratoga

Spec.—6-9-19—H. P. Co.—1000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19717 101 E 19717

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 630 N. Kenwood Ave. (WARD) 7th

2-FULL NAME Mary E. P. Linthicum

(a) RESIDENCE. (No.) 630 N. Kenwood Ave. 7th WARD.
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If nonresident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Female | White | Married |

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Oliver P. Linthicum

6 DATE OF BIRTH (month, day, and year) Jan. 22-1869

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 58 | 1 | 10 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER Wm. H. Glenn

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER Elizab. Jenkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Mrs. H. B. McNeill

(Address) 43 Rockwood Ave.

15 Filed 3/4/1927 G. HAMPSON JONES, M. D. Registrar

Per ARH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 4 - 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb. 27 - 1927, to Mar. 4 - 1927, that I last saw her alive on March 3 - 1927, and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edwin B. Fenby, M. D.

(Address) 1223 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| London Park | Mar 7 1927 |

20 UNDERTAKER: H. Von Cork

ADDRESS: 503 E. Fulton

Spec.—12-9-25—A Co.—200 Bks.

E 19718

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 19718

1-PLACE OF DEATH

City of BALTIMORE: (No. 5304 Anglewood Av St., (Hamilton) 43 Ward)

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robt. M. Taylor

(a) RESIDENCE NO. 5304 Anglewood Av St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. 11 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Mar 7/08

7 AGE

| Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|
| 18 | 11 | 25 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): City

(State or country)

PARENTS

10 NAME OF FATHER: Louis T. Taylor

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Grace V. Groth

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Md.

14 Informant: Louis T. Taylor

(Address): 5304 Anglewood Av

15 Filed 1927 By C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 2/27

17

I HEREBY CERTIFY, That I attended deceased from February 24, 1927, to March 2, 1927, that I last saw him alive on March 1, 1927, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(duration) Unknown

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Albert Duenberg, M. D.

3/3 1927 (Address) 2027 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Date of Burial 3/5 1927

20 UNDERTAKER: Philip Herwig Address 2016 Eutaw St

6-9-19—H. P. Co.—1000 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

19719

CERTIFICATE OF DEATH.

H. E 19719

1-PLACE OF DEATH 1333 Mosher St. REGISTERED NO. 16-24

CITY OF BALTIMORE: No 1333 Mosher ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Roddy

(a) RESIDENCE. No. 1333 Mosher St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred about 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: Luke Joseph Roddy

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years: about 50 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: John Tighe

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland.

12 MAIDEN NAME OF MOTHER: Mary McGrath

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Katherine Gilchrist. (Address) 1333 Mosher St.

15 Filed - 1927 C. HAMPSON JONES, M. D. Registrar. By ...

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): MAR - 4 1927

17 I HEREBY CERTIFY, That I attended deceased from April 5, 1924, to March 3, 1927, that I last saw her alive on March 3, 1927, and that death occurred, on the date stated above, at 1:00 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma uteri,
metastatic carcinoma,

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Gen'l toxaemia, anaemia

Cachexia (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of May 1924

Was there an autopsy? no

What test confirmed diagnosis? Phys. & Laboratory.

(Signed) Martin F. Baggott, M. D.

, 19 (Address) 1013 Monroe St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: 3/7-27

20 UNDERTAKER: Martin Fahey & Sons — ADDRESS: 1827 W. Fayette

Spec.—1-10-21—M&T—1500 Blks.

E 19720

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19720

## CERTIFICATE OF DEATH.

REGISTERED NO. 13

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Maryland General Hospital

CITY OF BALTIMORE, No. ~~William John Parker~~ 11-24 WARD)

2-FULL NAME Wm William John Parker

(a) RESIDENCE NO. Street, ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Mary Parker

6 DATE OF BIRTH (month, day, and year) June, 1864

7 AGE Years 63 Months 9 Days 17 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lancaster Co. Pa.

PARENTS

10 NAME OF FATHER James Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn.

12 MAIDEN NAME OF MOTHER Mary Knight

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant (Address) Son Hospital Records

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3 - 5 1927

17

I HEREBY CERTIFY, That I attended deceased from 3-2-27, 19 , to 3-5 , 1927

that I last saw h living on 3-5 , 19 27.

and that death occurred, on the date stated above, at 330 A. m.

The CAUSE OF DEATH* was as follows:

Stones in Urinary Kidney & Cystitis

CONTRIBUTORY (Secondary) Syphilis (duration) yrs. 1 mos. ds. Toxemia

~~Hypostatic pneumonia~~ (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. C. Zimmerman M.D. M. D.

, 19 (Address) Md. Genl Hospital, Balto, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lancaster Pa.

DATE OF BURIAL Mar 5th 1927

20 UNDERTAKER C. & B. Herle

ADDRESS 115 E. Fort St.

rc.—1 12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19721

## CERTIFICATE OF DEATH.

100-001

E 19721

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1814 E Lombard ST. 2-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margret Dowden

(a) RESIDENCE NO. 1814 E Lombard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? 80 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | W | Married |

If married, widowed, or divorced HUSBAND of (or) WIFE of Francis P Dowden

DATE OF BIRTH (month, day, and year) May 13 1845

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 81 | 9 | 24 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margret Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Francis P Dowden

(Address) 1814 E Lombard

15 Filed 1927, 19 C. HAMPSON JONES, M. D. Registrar

By RTH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 3d, 1927, to Mar 7, 1927.

that I last saw h[er] alive on Mar 3d, 1927

and that death occurred, on the date stated above, at 5:15 A m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Evidence

(Signed) A. T Rees, M. D.

Mar, 1927 (Address) 245 S. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Holy Redeemer | March 27 1927 |
| 20 UNDERTAKER | ADDRESS |
| Wendell Appelson | 37 Wilmot |

ec.—1-12-23—M&T—500 Blks.

001 E 19722

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1100 E 19722

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ~~JOHNS HOPKINS HOSP~~ ST., 7-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gene Baldwin

(a) RESIDENCE No. 225 E - Hall St. ST., WARD Savannah - Ga -

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Widowed |

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) 1857

| AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 70 | | | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Elec - Pat - Utility Bus -

(b) General nature of industry, business, or establishment in which employed (or employer) 29

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Ga -

PARENTS

10 NAME OF FATHER Hamel Baldwin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mass -

12 MAIDEN NAME OF MOTHER Hale Philbrick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ga -

14 Informant Records - (Address) JOHNS HOPKINS HOSPITAL

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per: ART

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 7, 1927, to March 4 1927, that I last saw him alive on March 4, 1927, and that death occurred, on the date stated above, at 3 a - m

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs mos 4 ds

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) Robert W. McKay, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Savannah Ga. DATE OF BURIAL Mch 6 1927

20 UNDERTAKER John O. Mitchell ADDRESS 1900 Eutaw Place

...c.—1-12-23—M&T—500 Bks.

E19723 HEALTH DEPARTMENT—CITY OF BALTIMORE E19723.

## CERTIFICATE OF DEATH.

159-002

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 626 N Streeper ST. 6-11 WARD)

2-FULL NAME William Panuska.

(a) RESIDENCE NO. 626 N. Streeper ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

If married, widowed, or divorced HUSBAND of (or) WIFE of —

DATE OF BIRTH (month, day, and year) Mar 4, 1927.

| AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | | | 1 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ... do

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER Wm Panuska

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Hilda Engelhardt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Wm Panuska

(Address) 626 N Streeper St

15 Filed 1927 HAMILTON JONES, M. D. Registrar

Per RC

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-5 1927

17 I HEREBY CERTIFY, That I attended deceased from 3-4, 1927, to 3-5, 1927

that I last saw h... alive on 3-4, 1927

and that death occurred, on the date stated above, at 3 A M.

The CAUSE OF DEATH* was as follows:

Congenital Heart

Immature Birth

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? ...

(Signed) Thos Supplee M. D.

1927 (Address) 700 N Bute

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Mar 7 1927

20 UNDERTAKER Geo M Trill & Son — ADDRESS Baltimore

Spec.—12-9-25—A Co.—200 Bks.

E 19724

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19724

## CERTIFICATE OF DEATH.

129

REGISTERED NO._____

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. _____ St. 13-59 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Sacks

(a) RESIDENCE NO. 2411 Etting St St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Negro | ? |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1871

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 56 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labourer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Va

PARENTS

10 NAME OF FATHER Tobe Sacks

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Eliza J. Hudson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant BALTIMORE CITY HOSPITALS

(Address) Records

15 Filed C. HAMPSON JONES, M. D. Registrar

MAR 10 1927 Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3 1927

17

I HEREBY CERTIFY, That I attended deceased from March 2, 1927, to March 3, 1927, that I last saw him alive on March 3, 1927, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Chronic Myocarditis

Generalized Anasarca

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY Myocardial Failure
(Secondary)

(duration) ...yrs. ...mos. 2 ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? General & Laboratory

(Signed) R Hodges Lynch, M. D.

Mch 4 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

JOHNS HOPKINS HOSPITAL

20 UNDERTAKER — ADDRESS

Commissioner Health MAR 5 - 1927

PUB. CO. R. WOOD

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19725

E 19725

## CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4907 Ross Road St. 22nd WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emily G Jones

(a) RESIDENCE NO. 4907 Ross road ST., WARD Deale Island Md.

(Usual place of abode) (If non-resident give city or town and State)

Leagth of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Jones

6 DATE OF BIRTH (month, day, and year) 12/17/1856

7 AGE: Years 70 Months 2 Days 19 If LESS than 1 day, ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dames Quarter Md

PARENTS

10 NAME OF FATHER Wm S Tyler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Leah Price

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Chas Jones (Address) 4907 Ross Road

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar.

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 25, 1927, to Nov 5, 1927, that I last saw h[illegible] alive on Nov 4, 1927, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Hemiplegia 5

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(duration) yrs. mos ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C H Thyer Jr., M. D.

Nov 5, 1927 (Address) 1527 E. 33rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Deale Island Md. DATE OF BURIAL Nov 8, 1927

20 UNDERTAKER John Ulrich ADDRESS 2508 Greenmount

ec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

19726 — 46 — E 19726

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 18-16 ST., WARD)

2-FULL NAME Miss Emma Despeaux

(a) RESIDENCE NO. 1323 Edmondson Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) April 1, 1873

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 53 | 11 | 3 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sales Lady

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Baltimore Md.

10 NAME OF FATHER Anthony Despeaux

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER Eliza Bobart

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

4 Informant (Address): Deceased.

5 Filed 1927 Per C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 4, 1927, to Mar 4, 1927, that I last saw her alive on Mar 4, 1927, and that death occurred, on the date stated above, at 7:15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Ovary (with probable metastases to Lungs.)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of Feb 10, 1927

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) J. J. Heroglity, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Mar 7 1927

20 UNDERTAKER: George L. Schwab — ADDRESS: 201 Fulton Ave.

Spec. -7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

Ok Cecil Mauck 7. 1926
V. L. L.

## CERTIFICATE OF DEATH

E 19727

E 19727 REGISTERED NO.

1-PLACE OF DEATH Colonial Hospital

City of BALTIMORE: (No. 1828 Lamont St., 4-28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Harcum

(a) RESIDENCE NO. 1828 Lamont St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: C

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth Harcum

6 DATE OF BIRTH (month, day, and year): December 1893

7 AGE: 34 Years 33 Months Days IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Odd

(c) Name of employer

9 BIRTHPLACE (city or town): Va

(State or country)

PARENTS

10 NAME OF FATHER: John E. Hankins

11 BIRTHPLACE OF FATHER (City or town): Va

(State or country)

12 MAIDEN NAME OF MOTHER: Sarah Ball

13 BIRTHPLACE OF MOTHER (city or town): Va

(State or country)

14 Informant: Elizabeth Harcum

(Address) 1828 Lamont St

15 Filed ..... 19 ..... Registrar

For KH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/3 1927

17 I HEREBY CERTIFY, That I attended deceased from 2/27 1927 to 3/3 1927

that I last saw h[illegible] alive on 3/3 1927

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows: Encephalitis Lethargica

(duration) ..... yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary): None

(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted? ?

If not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Brain removed

What test confirmed diagnosis? Phys. exam.

(Signed) John Gulstrom, M. D.

, 19 (Address) Colonial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemy — Date of Burial: Mar 7 '27

20 UNDERTAKER: Mrs R. A. Elliott — ADDRESS: 1225 Eutaw, Balto

Spec.—12-9-25—A Co—200 Bks.

E 19728

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-004 E 19728

## CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 624 Stuting St., 5-8 Ward)

2-FULL NAME Louisa Mary Clarke

(a) RESIDENCE NO. 624 Stuting St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hugh H Clarke

6 DATE OF BIRTH (month, day, and year): 1871

7 AGE: Years 55 | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Nurse

(b) General nature of industry, business, or establishment in which employed (or employer): O

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) England

PARENTS

10 NAME OF FATHER unk

11 BIRTHPLACE OF FATHER (city or town)

(State or country) unk

12 MAIDEN NAME OF MOTHER unk

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) unk

14 Informant: Rev Wilford Jones

(Address) 839 N Stricker St

15 Filed MAR 6 - 1927 C. HAMPTON JONES, M. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 25 1927, to March 1, 1927, that I last saw h[illegible] alive on March 1, 1927, and that death occurred, on the date stated above, at 8:15 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia Bilateral

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted? no

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) Geo S Allen, M. D.

Mar 5 1927 (Address) 508 Somerset St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Calvary — Date of Burial: Mar 6 1927

20 UNDERTAKER: Mrs. R. A. Elliott — ADDRESS: 1253 Rockwood

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19729

## CERTIFICATE OF DEATH.

REGISTERED NO. E 19729

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St., (16-23 31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Addison

(a) RESIDENCE NO. 808 N. Fremont st. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | Colored | Separated |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not stated

6 DATE OF BIRTH (month, day, and year) Unknown 1903

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| 24 | 36 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER John H. Addison

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Eleanor Pratt

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed ..... 19..... C. HAMILTON JONES M. D.

6-1927 Per ..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

March 4, 1927

17

I HEREBY CERTIFY, That I attended deceased from January 28, 19 27, to March 4, 19 27,

that I last saw him alive on March 4, 19 27,

and that death occurred, on the date stated above, at 1.15 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY

(Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) W. E. Gallemore, M. D.

3-4-27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Ashley Cemetery 3/7/27

20 UNDERTAKER ADDRESS

Mrs. R. G. Elliott 725 Ashland

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19730

1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

11-001

E 19730

REGISTERED NO.

City of BALTIMORE: (No. 229 Pearl St. 4-25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie Waters

(a) RESIDENCE NO. 229 Pearl St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem'l

4 Color or Race: C

5 Single, Married, Widowed, or Divorced. (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year): Unknown 1886

7 AGE: Years 41; Months; Days; IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER Wm Waters

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Caroline Waters

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant: Mrs A Thomas

(Address) 534 Pentz

Filed MAR 5 - 1927

C. HAMPSON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3 1927

17 I HEREBY CERTIFY, That I attended deceased from March 1 1927, to March 3, 1927, that I last saw h.. alive on March 3, 1927 and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) ..... yrs. ..... mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. W. Ward, M. D.

3/4 1927 (Address) 2205 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Date of Burial: Mt Auburn 3/5/27

20 UNDERTAKER: Mrs. Ida Linden ADDRESS: 1765

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

90 E 19731

E 19731 REGISTERED NO.

1-PLACE OF DEATH Balto City Hospitals (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Balto Md St. 16-67 WARD)

2-FULL NAME Marie Slade

(a) RESIDENCE NO. 3213 Presstman St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of James D Slade

6 DATE OF BIRTH (month, day, and year) 3 3 1850

7 AGE Years 77 Months Days If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Balto City Hospl. (Address) Balto Md

15 Filed 1927 HAMPSON JONES, M. D. Registrar

Per KH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-5 1927

17 I HEREBY CERTIFY, That I attended deceased from 1-22 1927 to 3-5 1927 that I last saw her alive on 3-4 1927 and that death occurred, on the date stated above, at 12.15 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

Terminal Bronchopneumonia

(duration) 1 yrs mos. ds.

CONTRIBUTORY (Secondary) ~~Influenza~~ & Senile Psychosis (duration) mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Harry Le Gouraud M.D.

, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Presbyterian, Govans Md DATE OF BURIAL 1927

20 UNDERTAKER H. A. Cook ADDRESS 507 E Fayette St

Spec.—7-17-26—A Co.—200 Blks.

Seabury 636 E Fort Ave

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19732

## CERTIFICATE OF DEATH

29 E 19732

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 728 East Fort Ave St. 24-33 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Thompson Jr

(a) RESIDENCE NO. 728 East Fort St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Eliza Thompson

6 DATE OF BIRTH (month, day, and year): Aug 16 1848

7 AGE: Years 78 79 | Months 6 | Days 16 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Wm Thompson

11 BIRTHPLACE OF FATHER (City or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Eliz Eichler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Elizabeth Thompson (Address) 708 E Fort Ave

Filed MAR 6 - 1927

C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar. 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 2, 1927, to Mar. 4, 1927, that I last saw h— alive on Mar 2 1927, and that death occurred, on the date stated above, at 4:50 a m.

The CAUSE OF DEATH* was as follows:

(Chronic Interstitial Nephritis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY Unknown (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Visual

(Signed) Geo. Seabury, M. D.

3/4, 1927 (Address) 636 Fort

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill

Date of Burial: 3/7 1927

20 UNDERTAKER: Wm Cook

ADDRESS: 502 E Balto

Spec.—7-17-26—A Co.—200 Bks.

Dr Airemore 1710 E 22nd St

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19733

## CERTIFICATE OF DEATH

Hamilton 27-43 129

E 19733

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Highland Road St. 27-43 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Gibbons

(a) RESIDENCE NO. Highland Road St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. da. How long in U. S. if of foreign birth? yrs. mos. da.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | W. | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick E Gibbons

6 DATE OF BIRTH (month, day, and year) Aug 13. 1852

| 7 AGE | Years | Months | Days | IF LESS than 1 day ... hrs. or ... min.. |
|---|---|---|---|---|
| | 74 | 6 | 20 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 37

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Peter Bozmango

11 BIRTHPLACE OF FATHER (City or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Catherine Johnnake

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Mrs. L. M. Anderson (Address) Highland Ave

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per RM

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 3 19 27

17 I HEREBY CERTIFY, That I attended deceased from Jan 1-27, 19..., to Mar 3-, 19 27

that I last saw h... alive on Mar 1-27, 19...

and that death occurred, on the date stated above, at 3 20 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 2 yrs. mos. da.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. 7 mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) + Edward J Thomas M. D.

Mch. 5-27 (Address) 1110 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Date of Burial Mar 6 1927

20 UNDERTAKER H. A. Cook ADDRESS 507 E North Ave

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

126 E 19734

## CERTIFICATE OF DEATH.

E 19734

REGISTERED NO. _____

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. _____ St. 14-20 Ward)

2-FULL NAME Eben P. Jones

(a) RESIDENCE NO. 1712 Etting St St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Negro | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Jones

6 DATE OF BIRTH (month, day, and year) 1871

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 56 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Maryland

PARENTS

10 NAME OF FATHER Charles W Jones

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Lizzie Posey

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Maryland

14 Informant _____

(Address) Records

15 Filed _____ 19 _____ C. HAMPDEN JONES, M. D. Registrar

86 - 1927 By _____

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2 1927

17 I HEREBY CERTIFY, That I attended deceased from January 28, 1927, to February 2, 1927, that I last saw h.. alive on March 1, 1927, and that death occurred, on the date stated above, at 2.45 A m.

The CAUSE OF DEATH* was as follows:

Chronic Peritonitis ideology not known
Chronic Myocarditis & Insufficiency

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) _____ yrs. _____ mos. 1 ds.

18 Where was disease contracted

If not at place of death? _____

Did an operation precede death? no Date of _____

Was there an autopsy? yes

What test confirmed diagnosis? general & laboratory

(Signed) R. Hooper Smith, M. D.

March 3 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chestown Md. Date of Burial March 6 1927

20 UNDERTAKER David Easton ADDRESS Paul

Spec.—1-10-21 M&T 1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 19735 REGISTERED NO. E 19735

1-PLACE OF DEATH Balto City Hospitals (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Balto Md ST., 72-30 WARD)

2-FULL NAME Vernon Jones

(a) RESIDENCE NO. 607 W. Conway St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1906

7 AGE: Years 21 Months Days If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Jamaica

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Balto City Hospitals Balto Md

15 Filed MAR 6 - 1927 Registrar C. HAMILTON JONES, M. D.

Per R.C.

Release p.m. Bay Vin 3/5/27.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3 - 2 1927

17 I HEREBY CERTIFY, That I attended deceased from 2 - 18, 1927 to 3 - 2 -, 1927.

that I last saw him alive on 3 - 1 -, 1927

and that death occurred, on the date stated above, at 2.40 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

Tuberculin Enteritis +

Peritonitis (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) Harry Feldmont M. D.

3/2/ 1927 (Address) Baltimore City Hospitals

*(State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem March 7 1927

DATE OF BURIAL

20 UNDERTAKER Harry Tinston

ADDRESS

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 19736 — REGISTERED NO. E 19736

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. 11-B Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Wilkerson

(a) RESIDENCE NO. 219 W. Chase st. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1886

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 40 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER Ben Wilkerson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant Hospital Records

(Address)

15 Filed 3-6 1927 C. HAMILTON JONES, M. D. Registrar

Per RK

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 March 4, 1927

17 I HEREBY CERTIFY, That I attended deceased from February 17 27, 19..., to March 4, 19 27,

that I last saw him alive on March 4, 19 27,

and that death occurred, on the date stated above, at 11.10A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Pulmonary Hemorrhage

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) W. E. Gatewood, M. D.

3-4-27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem Date of Burial March 6 1927

20 UNDERTAKER: Daniel Easter ADDRESS 976 Ba ave

c.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 19737

## CERTIFICATE OF DEATH.

REGISTERED NO. E 19737

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

ITY OF BALTIMORE: (NO. 1622 Mosher ST. 16-22 WARD)

2-FULL NAME Lillian Young

(a) RESIDENCE NO. 1622 Mosher ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1yr. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | Negro | Single |

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) March 18-1925

| AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 1 | 3 | 15 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~~Laborer~~ None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Clarence J. Young

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Ethel Young

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Ethel Young

(Address) 1622 Mosher St

15 Filed ~~1927~~ 1927 C. HAMPSON JONES, M. D. Registrar

Per R.L.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3 1927

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1927, to March 3, 1927, that I last saw her alive on March 1, 1927 and that death occurred, on the date stated above, at 2.50 p.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Bronchial

(duration) 2 yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) W. F. Jones M. D.

, 19 (Address) 1531 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Mt Auburn Cem | March 5 1927 |
| 20 UNDERTAKER Samuel Easton | ADDRESS 716 Cathedral |

c.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19738

CERTIFICATE OF DEATH.

E 19738

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 19-27 WARD)

2-FULL NAME Lana Cole

(a) RESIDENCE No. 1719 N. Franklin ST. City WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Colored | Single |

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Aug 2-1923

| AGE | Years | Months | Days | If LESS than 1 day, hrs or min |
|---|---|---|---|---|
| | 3 | 4 | 2 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md. Balto City

10 NAME OF FATHER James Cole

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Essie Montague

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

PARENTS

14 Informant Records. (Address) JOHNS HOPKINS HOSPITAL

15 Filed 1927 G. HALPIN JONES, M. D. Registrar

Per K.J.C.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb 26, 1927, to March 4, 1927, that I last saw her alive on March 4, 1927 and that death occurred, on the date stated above, at 6-50 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Exam of Spinal Fluid

(Signed) H. E. Handley, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lt. Calvert Bur. DATE OF BURIAL March 7 19 27

20 UNDERTAKER Daniel Carton ADDRESS

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19739

## CERTIFICATE OF DEATH.

E 19739

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 616-E-36th St. 9-47 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan C. Holzbach

(a) RESIDENCE No. 616 E. 36th St. WARD Virginia

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry - E. Holzbach

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days |
|---|---|---|---|
| | 70 | — | — |

If LESS than 1 day, ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Jersey

PARENTS

10 NAME OF FATHER Samuel Shelby -

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. J.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) W. E. Holzbach. R.F.D. 4 Richmond Va

15 Filed 6 1927 L. HAMPTON JONES, M. D. Registrar

By R.H.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6th 1927

17 I HEREBY CERTIFY, That I attended deceased from Feby 8th, 1927, to March 6th, 1927, that I last saw h[illegible] alive on March 5th, 1927 and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis -

Duration yrs. mos da.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 3 da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No -

What test confirmed diagnosis?

(Signed) Frederick D. Owen, M. D.

, 19 (Address) 2827 W. Cary St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Richmond Va — DATE OF BURIAL 3/6/1927

20 UNDERTAKER Mary A. Gaulthop — ADDRESS 2839 Kayne Ave

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19740

100-001

## CERTIFICATE OF DEATH.

REGISTERED NO. E 19740

1-PLACE OF DEATH Mercy Hospital

City of BALTIMORE: (No. [illegible] St., 7-12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank L. Wills-

(a) RESIDENCE NO. 1212 N. Montford Ave. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Annie E. Wills

6 DATE OF BIRTH (month, day, and year) Feb 24/65

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| 62? | 62 | — | 7 9 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Insurance

(c) Name of employer 066

9 BIRTHPLACE (city or town) Pa.

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Pa.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) " "

(State or country)

14 Informant Annie E. Wills

(Address) 1212 N. Montford Ave

15 Filed 6-1927 G. HAMPSON JONES, M. D. Registrar

Par RR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

3-3-27.

17

I HEREBY CERTIFY, That I attended deceased from 3-2, 1927, to 3-3, 1927, that I last saw him alive on 3-3-, 1927, and that death occurred, on the date stated above, at: 8:10 P. m.

The CAUSE OF DEATH* was as follows:

Patient was found unconscious in bed at 9 A.M. Died suddenly. Contributory Cause Pneumonia. Leucemia and Arteriosclerosis.

CONTRIBUTORY (Secondary) not known. 27 Riley Carney

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death Date of

Was there an autopsy

What test confirmed diagnosis

(Signed) E. Plassmeyer, M. D.

3/3. 1927 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem. Date of Burial 3/7 1927

20 UNDERTAKER Philip Herwig ADDRESS 2016 Orleans St

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 E 19741

E 19741

## CERTIFICATE OF DEATH.

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospital St., 10-37 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Freda Hasemann (Nasemann)

(a) RESIDENCE NO. 3925 E Balt St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 Color or Race: W-

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Conrad Hasemann

6 DATE OF BIRTH (month, day, and year): Jan 21/94

7 AGE: Years 33 | Months 1 | Days 11 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework.
(b) General nature of industry, business, or establishment in which employed (or employer): at Home
(c) Name of employer: None

9 BIRTHPLACE (city or town): Md.
(State or country)

PARENTS

10 NAME OF FATHER: Henry Thurn.

11 BIRTHPLACE OF FATHER (city or town):
(State or country): Germany

12 MAIDEN NAME OF MOTHER: Betty Schlentz

13 BIRTHPLACE OF MOTHER (city or town):
(State or country): Germany.

14 Informant: Conrad Nasemann
(Address) Georgia ave. (Essex)

15 Filed 6-1927 16 C. HAMILTON JONES, M. D. Registrar
Per KP

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: March 4. 1927

17 I HEREBY CERTIFY, That I attended deceased from 2-23, 1927, to 3-4, 1927
that I last saw h.. alive on 3-4, 1927
and that death occurred, on the date stated above, at 5 00 P. m.

The CAUSE OF DEATH* was as follows: Cholecystitis, Cholelethiasis

Duration: mos. ds.

CONTRIBUTORY (Secondary): Labor Pneum.

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 2-28-27

Was there an autopsy? No Operation Physical Signs

What test confirmed diagnosis? Surgical

(Signed) M. D.

. 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem. Date of Burial 3/8 1927

20 UNDERTAKER: Philip Herring ADDRESS 2016 Aliceanna St

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 19742

90 E 19742

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1018 W. Lanvale St. 16-23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME C. Virginia Albaugh

(a) RESIDENCE NO. 1018 W. Lanvale St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 1 mos. 4 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 31, 1861

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|---|
| | 66 | 1 | 4 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School Teacher
(b) General nature of industry, business, or establishment in which employed (or employer) Retired (2 yrs) 66
(c) Name of employer Baltimore

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER John Albaugh

11 BIRTHPLACE OF FATHER (City or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Amelia White

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Mrs. Evelyn Demames
(Address) 1018 W. Lanvale St.

15 Filed ..... 1927 ..... 12 ..... C. HAMPSON JONES, M. D. Registrar

By ..... P.T.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 4 19 27

17 I HEREBY CERTIFY, That I attended deceased from Feb. 14th, 19 27, to March 4, 19 27, that I last saw h[er] alive on March 4th, 19 27, and that death occurred, on the date stated above, at 3.15 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy followed by Paralysis

(duration) yrs. mos. 2 da.

CONTRIBUTORY (Secondary) Valvular Heart disease (Mitral)

(duration) 5 yrs. 1 mos. 1 da.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual Signs

(Signed) D. A. Waldron, M. D.

, 19 (Address) 210 East Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery Date of Burial Mar 7 1927

20 UNDERTAKER Wm. Hickey Sons ADDRESS North & Pa

c.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

19743

## CERTIFICATE OF DEATH.

001

101 E 19743

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

ITY OF BALTIMORE: (No. 838 N. Fulton ave. 18-26 WARD)

2-FULL NAME Ada Katharine Brewer

(a) RESIDENCE NO. 838 N. Fulton Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

If married, widowed, or divorced, HUSBAND of (or) WIFE of Chas. C. P. Brewer

DATE OF BIRTH (month, day, and year) Oct 18 1854

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 72 | 4 | 15 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

BIRTHPLACE (city or town) (State or country) Gettysburg Pa

10 NAME OF FATHER Allen F. Baugher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Eliza Beck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant (Address) Mrs. A. Donaldson Edmondson

15 Filed MAR 5 - 1927 C. HAMPTON JONES, M. D. Registrar

Prepared

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb - 28, 1927, to March - 5, 1927, that I last saw h[illegible] alive on March - 5, 1927 and that death occurred, on the date stated above, at 3 4 m

The CAUSE OF DEATH* was as follows:

Acute Hypertrophy of Heart (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Martin A. Shook, M. D.

3-5-1927 (Address) 8064 Fulton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Loudon Park | March 7 1927 |
| 20 UNDERTAKER Wm. J. Reuscher Sons | ADDRESS Northern |

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19744 — CERTIFICATE OF DEATH. — E 19744

REGISTERED NO. .....

1-PLACE OF DEATH Franklin Square Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Fayette & Calhoun Sts ST. ) WARD)

2-FULL NAME Mrs. Hester Carrigo

(a) RESIDENCE NO. 854 W 37th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank Carrigo

6 DATE OF BIRTH (month, day, and year): March 15 1873

7 AGE — Years: 53 — Months: 11 — Days: 19 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Frank F. Carrigo 854 W 37th St

15 Filed ... 19 ... C. HAMPSON JONES, M. D. Registrar

6 - 1927 By ...

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 4 1927

17 I HEREBY CERTIFY, That I attended deceased from 2/10/27 19 ... to 3/4/27 19 ...

that I last saw h[illegible] alive on 3/4/27 19 ... at 2.45 p m.

and that death occurred, on the date stated above, at 2 p m.

The CAUSE OF DEATH* was as follows:

Primary Cancer Peritonei

2/10/27 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation Embolism

2/[illegible]/27 (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? Yes Date of 2/27/27

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) W Walter Walker M.D.

19 (Address) Franklin Sq Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: March 8 1927

20 UNDERTAKER: Eckenrode & Son — ADDRESS: 1367 Chestnut Ave

...c.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

19745

## CERTIFICATE OF DEATH.

151 ✓ E 19745

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH West Baltimore General Hospital

CITY OF BALTIMORE: (No. Rayner and Dukeland ST. 12-5 WARD)

2-FULL NAME Joseph Lentz

(a) RESIDENCE NO. 449 Lechester ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of: May Lentz

DATE OF BIRTH (month, day, and year): March 25 1868

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| 58 | 59 | 11 | 27 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baggage Agent

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Md

10 NAME OF FATHER: Edward Lentz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Caroline Rahrbaugh

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant: Russell Lentz

(Address) 449 Lechester Ave

Filed , 19 C. HARRISON JONES, M.D.

Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/5 1927

17 I HEREBY CERTIFY, That I attended deceased from 3/4 1927 to 3/5 1927.

that I last saw him alive on 3/5 1927

and that death occurred, on the date stated above, at 5:30 A m.

The CAUSE OF DEATH* was as follows:

Uremia extravasation

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Gangrene of scrotum and penis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of 3/4/27

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Benjamin Wilbur, M. D.

19 (Address) W. B & H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| London Park | March 7 1927 |
| UNDERTAKER | ADDRESS |
| Chenowith & Son | 3417 Chestnut Ave |

Spec.-7-17-26—A Co.—200 Bks.

Plauger

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19746

## CERTIFICATE OF DEATH

1-001

E 19746

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. St Agnes Hospital 25-72 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alton Plauger

(a) RESIDENCE NO. Ellicott City Md St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 21 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year) July 7, 1905 - 27 1907

7 AGE: Years 19 Months 8 Days 1

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Saw Mill Hand.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Va 046

9 BIRTHPLACE (city or town)

(State or country)

PARENTS

10 NAME OF ~~FATHER~~ W E. Plauger

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Emiseth L. McIntuff

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant Chas. Plauger Ellicott City

(Address)

15 Filed 6 - 1927

C. HAMPSON JONES, M. D. Registrar

Per R K

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3 - 5 - 27 19

17 I HEREBY CERTIFY, That I attended deceased from 2-12, 1927, to 3-5, 1927, that I last saw him alive on 3-5, 1927, and that death occurred, on the date stated above, at 11:50 P m.

The CAUSE OF DEATH* was as follows:

Peritonitis, generalized due to perforation of ulcer in ileum

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Typhoid Fever

(duration) yrs. mos. 1 0 ds.

18 Where was disease contracted

If not at place of death? Ellicott City, Md

Did an operation precede death? Yes Date of 3/5/27

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Theron Hunter, M. D.

3/5/ 1927 (Address) St. Agnes' Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodstock, Virginia

Date of Burial: May 7, 1927

20 UNDERTAKER: Eaton Son

ADDRESS: Ellicott City

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

19747 E 19747

## CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2911 Allendale Road St. 15-61 WARD)

2-FULL NAME William Arthur Townsend Jr.

(a) RESIDENCE NO. 2911 Allendale Road ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W.

5 Single, ~~Married, Widowed,~~ or Divorced. (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 5-1915

7 AGE — Years: 11 — Months: 9 — Days: — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer): old

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Wm A Townsend Jr

11 BIRTHPLACE OF FATHER (city or town) Carroll Co (State or country) Md.

12 MAIDEN NAME OF MOTHER Pearl Maguire

13 BIRTHPLACE OF MOTHER (city or town) Carroll Co (State or country) Md

14 Informant (Address) Mrs W A Townsend Jr 2911 Allendale Road

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

R6 - 1927 Per RC

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5th 1927

17 I HEREBY CERTIFY, That I attended deceased from July 8, 1926, to Mar 5, 1927, that I last saw him alive on Mar 4 1927, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Endocarditis Chronic

(duration) 8 yrs. 0 mos ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Elaine Joslin, M. D.

Mch 1927 (Address) 1017 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery — DATE OF BURIAL: Mar 7th 27

20 UNDERTAKER: Putnam & Gore — ADDRESS: 1723 Eutaw Place

c.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19748

## CERTIFICATE OF DEATH.

74-001 E 19748

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No.) 2100 E Baltimore ST. 6-9 (WARD)

2-FULL NAME Morris Gerolnick

(a) RESIDENCE No. 132 N Broadway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? 13 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): married

If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna Gerolnick

DATE OF BIRTH (month, day, and year): Unknown

| AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 45 | — | — | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Ladies Tailor

(b) General nature of industry, business, or establishment in which employed (or employer): 080

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Joseph Gerolnick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unk

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Lewis

(Address) 1439 E Baltimore st

15 Filed ..., 19 C. HAMPSON [illegible], M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 25 19 27

17 I HEREBY CERTIFY, That I attended deceased from June, 19 27, to June 25, 19 27

that I last saw h[illegible] alive on June 25, 19 27

and that death occurred, on the date stated above, at 6 P m

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Hypertension

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Lewis Schlossman M. D.

, 19 (Address) 1810 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Herrun Rus — DATE OF BURIAL: 7/6 1927

20 UNDERTAKER: Jack Lewis 1439 E Baltimore st — ADDRESS

e.—1-12-23—M&T—500 Blks.

758

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 19749

## CERTIFICATE OF DEATH

E 19749

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 10-14 WARD)

2-FULL NAME Sam Weiner

(a) RESIDENCE NO. 814 Fremont ST Ave WARD City
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

If married, widowed, or divorced HUSBAND of (or) WIFE of —

DATE OF BIRTH (month, day, and year) Unknown

| AGE | Years | Months | Days | If LESS than 1 day, hrs or min |
|---|---|---|---|---|
| | 18 yrs. | | | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Und —

10 NAME OF FATHER Israel Weiner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Fanni Bros

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Records — (Address) JOHNS HOPKINS HOSP

15 Filed — 1927 C. HAMPSON JONES, M. D. Registrar

Per —

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1927

17 I HEREBY CERTIFY, That I attended deceased from March 2, 1927, to March 4, 1927, that I last saw him alive on March 4, 1927 and that death occurred, on the date stated above, at 2 40 P. M.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia
(Pneumococcus Type III)

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) Septicemia
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray

(Signed) Milton Sherry, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Sinai Rest

DATE OF BURIAL 3-8 1927

ADDRESS

20 UNDERTAKER Jack Levin 1439 Eutaw St

Spec.—12-9-25—A Co.—200 Bks.

Hom-

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 19750

# CERTIFICATE OF DEATH.

E 19750

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St., 7-13 Ward)

2-FULL NAME Tillie Hom

(a) RESIDENCE NO. 9142 N. Broadway St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? 17 yrs. ___ mos. ___ ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jessie Hom

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE: Years 47; Months —; Days —; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Russia

14 Informant Jessie Hom

(Address) 9142 N. Broadway

15 Filed APR 6 - 1927 L. HAMPSON JONES, M.D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/31 1927

17 I HEREBY CERTIFY, That I attended deceased from 3/21, 1927, to 3/31, 1927, that I last saw her alive on 3/31, 1927, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) ___ yrs. ___ mos. 15 ds.

CONTRIBUTORY (Secondary)

(duration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted (if not at place of death)? ?

Did an operation precede death? No Date of_____

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Facts. X Ray

(Signed) John A. Aosen, M. D.

3/5, 1927 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale — Date of Burial 4/6 1927

20 UNDERTAKER: Jack Lewis — ADDRESS 1439 E. Eager St

ec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19751

## CERTIFICATE OF DEATH.

91-002

E 19751

REGISTERED NO.

1-PLACE OF DEATH Bon Secours Hospital 14-28

CITY OF BALTIMORE: (No. West Fayette St. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Mary J Greene

(a) RESIDENCE No 1606 N. Pratt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of or (6b) WIFE of

7 DATE OF BIRTH (month, day, and year) Dec. 13, 1872

8 AGE: Years 54 Months 2 Days 19 If LESS than 1 day, ..... hrs. or ..... min.

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

10 BIRTHPLACE (city or town) Baltimore, (State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Greene

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Dunsworth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Mrs. Katherine Galvin #613 Copley Court Apts. Washington, D. C.

15 Filed MAR 8 - 1927 19 C. HARRISON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 27, 1927, to Mar. 4, 1927, that I last saw her alive on Mar. 4, 1927, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral arteriosclerosis

Cerebral Edema

(duration) — yrs. — mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Geo. D. Lippay, M. D.

(Address) Bon Secours Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery

DATE OF BURIAL: Mar. 8 1927

20 UNDERTAKER: Joseph F. Cook

ADDRESS: 1003 N. Eutaw St.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

100-001

E 19752

REGISTERED NO. E 19752

E 19752
1-PLACE OF DEATH

City of BALTIMORE: (No. 2905 Frederick Ave. St. 20-70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Edmonston

(a) RESIDENCE NO. 2905 Frederick Ave. St. Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Julia E. Edmonston

6 DATE OF BIRTH (month, day, and year) September 14, 1867

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|---|
| | 69 | 5 | 19 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Foreman 086
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Loudon Park Cemetery Co

9 BIRTHPLACE (city or town)
(State or country) Baltimore Co., Md.

PARENTS

10 NAME OF FATHER Alexander Edmonston

11 BIRTHPLACE OF FATHER (City or town)
(State or country) FrederickCo., Md.

12 MAIDEN NAME OF MOTHER Sarah Winpenny

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) England

14 Informant Leslie O. McCloskey
(Address) 2652 Pennsylvania Ave.

MAR 6 - 1927

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19
March 3, 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 15, 1927, to March 3, 1927, that I last saw him alive on March 3, 1927, and that death occurred, on the date stated above, at 5.20 p. m.

The CAUSE OF DEATH* was as follows: Bronchopneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. ds.

18 Where was disease contracted —

If not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical findings

(Signed) Herbert E. Zeyer M. D.

3-4 . 19 27 (Address) 3048 W. North Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
Loudon Park Cemetery

Date of Burial
Mar. 7 1927

20 UNDERTAKER Joseph B Cook

ADDRESS 1043 Park Ave

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19753

## CERTIFICATE OF DEATH.

29 E 19753

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. German Aged Home St. Baltimore & Dyson Sts 70-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ludwig Wm Koh

(a) RESIDENCE NO. German Aged Home St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Augusta Koh

6 DATE OF BIRTH (month, day, and year) April 26, 1845

| 7 AGE Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|
| 81 | 10 | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER August Koh

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Henrietta Walk

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Records. Germany Home

(Address) Balto & Dyson Sts

15 Filed ....., 19..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 19 27

17

I HEREBY CERTIFY, That I attended deceased from Jan, 1927, to March 3rd, 1927, that I last saw him alive on March 3rd, 1927, and that death occurred, on the date stated above, at 7 30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) John Hauff, M. D.

(Address) 1843 W. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Ceme Date of Burial Mar 7 1927

20 UNDERTAKER Joseph L Cook ADDRESS 1002 N Eutaw

c.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 19754 — E 19754

1-PLACE OF DEATH 843 s. Dallas st. Balto Md — REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No. 843 ST., 3-4 WARD)

2-FULL NAME Mary Grutkowski

(a) RESIDENCE NO. 843 s. Dallas st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Leagth of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? 49 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | W | Widowed |

If married, widowed, or divorced HUSBAND of (or) WIFE of Albert grutkowski

DATE OF BIRTH (month, day, and year) 5/13 1852

| AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 74 | 9 | 21 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeping

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Poland

10 NAME OF FATHER Waba

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Waba

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

Informant Mrs Frances Sypniewski

(Address) 2421 Baker st

Filed ..... 19..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1927

17 I HEREBY CERTIFY, That I attended deceased from March 3, 1927, to March 4, 1927, that I last saw her alive on March 3, 1927 and that death occurred, on the date stated above, at 10.30 a. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? General examination

(Signed) Jos. A. Rosenblatt, M. D.

3/4, 1927 (Address) 3018 O'Donnell st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Holy Rosary Cem | March 8 1927 |
| 20 UNDERTAKER | ADDRESS |
| John M Welsh | 1803 Bank st |

AUG 6 1926 C. HAMILTON JONES, M.D.

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

11-002 E 19755

## CERTIFICATE OF DEATH

E 19755 REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2723 Hudson St St 1-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Gorski

(a) RESIDENCE NO. 2723 Hudson St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S. if of foreign birth? 13 yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Gorski

6 DATE OF BIRTH (month, day, and year) July 24 1887

| 7 AGE | Years | Months | Days |
|---|---|---|---|
| | 39 | 7 | 7 |

IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Housework 037

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Poland

PARENTS

10 NAME OF FATHER Jan Suckcicki

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Frank Gorski

(Address) 2723 Hudson St

15 Filed MAR 6 - 1927 19 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

March 3 1927

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1927, to March 3, 1927,

that I last saw her alive on March 3, 1927,

and that death occurred, on the date stated above, at 11.30 P.m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) I. B. Bronushas, M. D.

3-5-27 19 (Address) 3037 O'Donnell St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Holy Rosary Cem — Date of Burial March 7 1927

20 UNDERTAKER John M Weber — ADDRESS 1803 Bank St

ec.—1-12-23—M&T—500 Bks.

E 19756

# HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 19756

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 417 W 24th St. 12-51 (WARD)

2-FULL NAME Thomas C Farley

(a) RESIDENCE NO. 417 W 24th St., WARD

(Usual place of abode)

(If non-resident give city or town and State)

length of residence in city or town where death occurred 5/a yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced HUSBAND of (or) WIFE of: Florence Farley

DATE OF BIRTH (month, day, and year): July 8 1887

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 39 | 7 | 24 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: P R Brakeman

(b) General nature of industry, business, or establishment in which employed (or employer): 073

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Frank Farley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Margaret Murray

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Mrs Florence Farley 417 W 24th St

15 Filed MAR 6 - 1929, 19 HARRY M. JONES Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1927, to March 4, 1927, that I last saw h alive on March 4, 1927, and that death occurred, on the date stated above, at 2.40 P m.

The CAUSE OF DEATH* was as follows:

I My accidental Injuries

Cardiac Hypertrophy

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary): Endocarditis, Mitral Stenosis (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P. S. & Symptoms

(Signed) Thomas J Mills M. D.

, 19 (Address) 5-32-E-22nd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| St Josephs Cem. Texas Md | Mar 3 1927 |
| 20 UNDERTAKER: Geo A Farley | ADDRESS: Fulton Md |

...—1-12-23—M&T—500 Blks.

19757

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. 19757

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 25 Forman Ave 20-69 WARD)

If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Victoria Kaufman

(a) RESIDENCE NO. 25 Forman Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widowed |

If married, widowed, or divorced HUSBAND of (or) WIFE of Casper Kaufman

DATE OF BIRTH (month, day, and year) May 2 1847

| AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 79 | 10 | 2 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Frank J. Kaufman

(Address) 25 Forman Ave

Filed Mar 8 1927 Per C. HAMPTON JONES, M.D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb. 4, 1927, to March 4, 1927,

that I last saw her alive on March 3, 1927

and that death occurred, on the date stated above, at m

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder

(duration) four yrs. — mos — ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) — yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) M Baumanstark, M. D.

3/5, 1927 (Address) 626 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL 3-7 1927

UNDERTAKER Leopold Straley ADDRESS Fulton & Fayette

Spec.—7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19758

## CERTIFICATE OF DEATH

113

E 19758

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 513 Beaumont St. 27-48 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Holland Dilworth

(a) RESIDENCE NO. 513 Beaumont St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. / mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 2nd 1927

7 AGE: Years 1 Months Days 3 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town): City

(State or country)

PARENTS

10 NAME OF FATHER J. G. Dilworth

11 BIRTHPLACE OF FATHER (City or town) Ford

(State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Ethel Holland

13 BIRTHPLACE OF MOTHER (city or town) City

(State or country)

14 Informant J. G. Dilworth

(Address) 513 Beaumont

15 Filed MAR 6 - 1927 16 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 March 5 - 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 2 1927 to Mar 5 1927

that I last saw him alive on Mar. 4 1927

and that death occurred, on the date stated above, at 6.45 A. m.

The CAUSE OF DEATH* was as follows:

Gen. Adenitis

(duration) yrs. / mos. ds.

CONTRIBUTORY (Secondary) Gastro-Intestinal Infection Due to Mastoiditis & Otitis

(duration) yrs. / mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. C. Stokes, M. D.

3-6 1927 (Address) 5600 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

Date of Burial: 3/6 1927

20 UNDERTAKER: J. J. Moran

ADDRESS 300 E. Preston

Spec.-7-17-26—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19759

## CERTIFICATE OF DEATH

129

REGISTERED NO. E 19759

1-PLACE OF DEATH

City of BALTIMORE: (No. 607 S. Curley St. 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Friess

(a) RESIDENCE NO. 607 S. Curley St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 71 yrs. 8 mos. 6 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | W | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry L. Friess

6 DATE OF BIRTH (month, day, and year) Jan 16-1855

| 7 AGE | Years | Months | Days | IF LESS than 1 day ... hrs. or ... min.. |
|---|---|---|---|---|
| | 71 | 8 | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) — 07

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER John Snyder

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant (Address) Henry Friess 607 S. Curley St.

15 Filed MAR 6 - 1927 19 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3. 27 19

17 I HEREBY CERTIFY, That I attended deceased from Feb. 27, 27, to March 3, 1927

that I last saw h[er] alive on March 3, 1927

and that death occurred, on the date stated above, at 3:40 P.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Arteriosclerosis

Left Hemiplegia (Complete)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. Joseph Fowler M. D.

, 19 (Address) 720 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Old Town Cem

Date of Burial 3/7 1927

20 UNDERTAKER J. H. Moran

ADDRESS 300 E Balto St.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

19760

## CERTIFICATE OF DEATH.

90 ✓

E 19760

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Katherine Krisman 76-37 Ward)

2-FULL NAME 632 S. 5th St

(a) RESIDENCE NO. 632 S 5th St St. Ward

(Usual place of abode)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 State, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Isadore Krisman

6 DATE OF BIRTH (month, day, and year): 1861

7 AGE — Years: 66 — Months: — Days: — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Austria

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Austria

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Austria

14 Informant (Address): Wm. Krisman 1909 Eastern Ave.

15 Filed ..... 19 .....

HAMPTON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

3/3/27

17 I HEREBY CERTIFY, That I attended deceased from 3/2, 1927, to 3/3, 1927, that I last saw h.er alive on 3/3, 1927, and that death occurred, on the date stated above, at 9:00 p m.

The CAUSE OF DEATH* was as follows:

Arteris Sclerosis & Chronic myocarditis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Acute Cardiac dilatation

— (duration) — yrs. — mos. — ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. McGarrell, M. D.

3/6, 1927 (Address) 633-S-3rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Trappe Road

Date of Burial: Mar 7, 1927

20 UNDERTAKER: Geo. G. Cook

ADDRESS: 1723 W. Pattersons Pk

R6 - 1927

ec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19761

## CERTIFICATE OF DEATH.

E 19761

1-PLACE OF DEATH St Joseph's Hospital

CITY OF BALTIMORE: (No.) 9-17 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Wilmer Stevens

(a) RESIDENCE NO. Fair Lee Kent Co Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State) New Rock Hall-Md.

Length of residence in city or town where death occurred 0 yrs. 0 mos. 26 ds. How long in U. S., if of foreign birth? 65 yrs. 11 mos. 8 ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | white | Married |

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Lilian R Stevens

DATE OF BIRTH (month, day, and year) April 25, 1861

| AGE | Years | Months | Days | If LESS than 1 day, hrs or min |
|---|---|---|---|---|
| | 65 | 11 | 8 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer Retired

9 BIRTHPLACE (city or town) (State or country) Kent County Maryland.

PARENTS

10 NAME OF FATHER William Stevens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Talbot County Maryland.

12 MAIDEN NAME OF MOTHER Rebecca Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kent County Maryland

14 Informant Mrs James W Stevens (Address) Chestertown, Md

15 Filed APR 6 - 1927 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/5 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 7, 1927, to March 5, 1927, that I last saw h— alive on March 5, 1927, and that death occurred, on the date stated above, at 10 21 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Arteriosclerosis

about

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia & Cardiac failure about 2 ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Laboratory

(Signed) C Vernon S. Wynne, M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rock Hall, Kent Co., Md.

DATE OF BURIAL Mar-8-27

20 UNDERTAKER STEWART & MOWEN COMPANY

ADDRESS 108 W. NORTH AVE.

Spec.—1-10-21—M&T—1500 Bks.

19762

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

12-19 43

E 19762

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 18 E. Lafayette Avenue ST., (WARD)

2-FULL NAME Helen Beauregard McKew Parr

(a) RESIDENCE NO. 18 E. Lafayette Avenue ST., WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 8 mos. 20 ds. How long in U. S., if of foreign birth? 64 yrs. 8 mos. 20 ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widowed |

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles E. Parr

7 DATE OF BIRTH (month, day, and year) June-15-1862

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 64 | 8 | 20 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Dennis I McKew

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Victorine S. Hilger

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mr. McKew Parr, (son)
(Address) 77 Waren St. New York, N.Y.

15 MAR 6 - 1927 C. HARRISON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5 1927

17 I HEREBY CERTIFY, That I attended deceased from ..., 1921, to March 5, 1927, that I last saw her alive on March 4, 1927, and that death occurred, on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Tongue

(duration) 1 yrs. 3 mos 1 ds.

CONTRIBUTORY (Secondary) Adenoma of Tongue (duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Microscopic Examination Piece of Tongue Removed 1921

(Signed) Donald V. Leberecombe, M. D.

2/5, 1927 (Address) 184 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL Mar-7-27

20 UNDERTAKER STEWART & MOWEN COMPANY — ADDRESS 108 W. NORTH AVE.

MATTHEW

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19763 E 19763

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 249 McCurley St. 20-10 REGISTERED NO.

CITY OF BALTIMORE: (No. S. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Matthews Boone.

(a) RESIDENCE No. 249 Mc Curley. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married.

If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie Elizabeth McCauley

DATE OF BIRTH (month, day, and year): 3-8-1874.

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| 5-2 | | 11 | 27 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Mail Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer): Railway Mail Clerk

(c) Name of employer: U.S.

BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: MATTHEW Boone.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ellicott City Md.

12 MAIDEN NAME OF MOTHER: Mary Dand.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Lynchburg Va.

14 Informant: Evelyn L. Boone.

(Address): 249 McCurley St.

15 Filed 6 1927, 19 C. HAMILTON JONES, M. D. Registrar

Per

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3-5-27 19

17

I HEREBY CERTIFY, That I attended deceased from Mar 1, 1927, to Mar 5, 1927, that I last saw him alive on Mar 5, 1927, and that death occurred, on the date stated above, at 12 30 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Lobar)

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) myocarditis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Phy

(Signed) Fred T. Kyper M. D.

, 19 (Address) 3320 Fredb Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: 3/7/27

20 UNDERTAKER: Martin Fahey Sons. — ADDRESS: 1827 W Mtham

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 19764 — 31 — E 19764

1-PLACE OF DEATH University Hospital — REGISTERED NO.

City of BALTIMORE: (No. 2-8-63 St.)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara Carrigan

(a) RESIDENCE NO. 4218 Kensington St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

| 7 AGE | Years | Months | Days | IF LESS than 1 day ... hrs. or ... min.. |
|---|---|---|---|---|
| | 32 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Patrick Carrigan

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Brady

13 BIRTHPLACE OF MOTHER (city or town) Balto.

(State or country)

14 Informant Harry M Corrigan

(Address) 402 18 Kensington Ave

15 Filed MAR 6 - 1927 C. HAMPSON JONES, M. D. Registrar

By RK

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/5/27 19

17 I HEREBY CERTIFY, That I attended deceased from 3/1/27, 19..., to 3/5/27, 19...,

that I last saw her alive on 3/5/27, 19...,

and that death occurred, on the date stated above, at 11 05 A.M. m.

The CAUSE OF DEATH* was as follows:

Bilateral Pulmonary Tuberculosis - Pneumonic Type

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous Pneumonia - Bronchi.

(duration) yrs. mos 14 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? TB, bacilli & pneum

(Signed) J. S. Winstead, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — Date of Burial 3/7-27

20 UNDERTAKER Martin Fahey Sons — ADDRESS [illegible]

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19765

## CERTIFICATE OF DEATH.

90 ✓

REGISTERED NO. E 19765

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 817 N. Lakewood Ave WARD) 12

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna C. Kandler Schreiber

(a) RESIDENCE NO. 817 N. Lakewood ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced; (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm. Schreiber

6 DATE OF BIRTH (month, day, and year): Jan 22 1855

7 AGE — Years: 72 — Months: 0 — Days: 10 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER: Albert Hoffman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Louise Pomeranke

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Louise Pfeland

(Address) 817 N. Lakewood ave

15 Filed MAR 6 - 1927 CHANDLER JONES, M. D. Registrar

By [illegible]

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 4 1927

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1927, to March 4, 1927, that I last saw h[illegible] alive on March 4, 1927, and that death occurred, on the date stated above, at 1. P. m.

The CAUSE OF DEATH* was as follows:

arterio-Sclerosis
arterial Hypatension or
Myocarditis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary): Broncho-pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phy exam - Ch

(Signed) Louis F. Krumeine M. D.

, 19 (Address) 722 N. Kenwood ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western — DATE OF BURIAL: Mar 8 1927

20 UNDERTAKER: Chas. Wm. J. W. Teufel & Son — ADDRESS: 801 W Fayette

For [illegible] this certificate I have known her.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

9766

## CERTIFICATE OF DEATH.

41

E 19766

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hosp St. 6-10 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Schabdach

(a) RESIDENCE NO. 426 Sheepshead St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | white | Wid |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. Schabdach

6 DATE OF BIRTH (month, day, and year) Oct 15. 1872

| 7 AGE Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|
| 54-4-17 | 4 | 19 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Germany

(State or country)

PARENTS

10 NAME OF FATHER David Eger

11 BIRTHPLACE OF FATHER (city or town) Germany

(State or country)

12 MAIDEN NAME OF MOTHER Rosina Seidloff

13 BIRTHPLACE OF MOTHER (city or town) Germany

(State or country)

14 Informant Louis Schabdach

(Address) 420 N. Linwood

MAR 6 - 1927

HAMILTON JONES, M. D.

Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Infected Gland of neck.

Con. 1 week.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Septicaemia

(duration) .....yrs. .....mos. .....ds.

(Signed) W. S. Riley, M. D.

(Coroner)

Mch. 5 1927 (Address) 1639 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem Date of Burial Mar 7 1927

20 UNDERTAKER Mr. & Mrs. John W. Tenfelde Son ADDRESS 801 W. Fayette

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19767

## CERTIFICATE OF DEATH.

88-003 E 19767

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. Gen. Hosp. St. 13-54 Ward)

2-FULL NAME Jacob Schaslow

(a) RESIDENCE NO. 2811 Parkwood Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| male | white | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Schaslow

6 DATE OF BIRTH (month, day, and year) About 1859

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or.....min. |
|---|---|---|---|---|
| | 68 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of indnstry, business, or establishment in which employed (or employer) Self.

(c) Name of employer

9 BIRTHPLACE (city or town) Russia

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Minnie Schaslow

(Address) 2811 Parkwood Ave

15 Filed ..... 19 C. HAMPSON JONES, M. D. Registrar

MAR 6 - 1927 Per

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Fracture of left clavicle Laceration of r. leg. Struck by automobile (accidental)

CONTRIBUTORY (Secondary) Cerebral Oedema (duration) yrs. mos. 5 ds.

(duration) yrs. mos. 1 ds.

(Signed) J. J. Hennessy M. D. (Coroner)

March 5, 1927 (Address) 280 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Washington Rd

Date of Burial 3/4 1927

ADDRESS

UNDERTAKER Park Lane 1439 E Baltimore

Spec.—1-16-21—M&T—1500 Bks.

E 19768

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

101-001

REGISTERED NO. E 19768

1-PLACE OF DEATH Franklin Sq. Hosp. CITY OF BALTIMORE: (NO. ..... ST., 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth White

(a) RESIDENCE NO. 921 McCulloh ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: B

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible] 1882

7 AGE: 45 (Years / Months / Days; If LESS than 1 day, hrs. or min.)

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Cabot Co. Md.

PARENTS

10 NAME OF FATHER: Robt White

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Catherine Parker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Isaac White
(Address) 1352 N. Stricker

15 Filed MAR 7 1927 19 C. HAMPSON JONES, M. D. Registrar
By [illegible]

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-7 1927

17 I HEREBY CERTIFY, That I attended deceased from 2-25 1927 to 3-4 1927.
that I last saw her alive on 3-4 1927.
and that death occurred, on the date stated above, at 4.35 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Myocardial Degeneracy (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Clinical

What test confirmed diagnosis?

(Signed) W Wallace Walker M. D.

19 (Address) Franklin Sq. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL 3-7 1927

20 UNDERTAKER: John N. Toadvine — ADDRESS 1027 Edmondson Ave

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19769

## CERTIFICATE OF DEATH.

15 E 19769

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 620 S. Para ST. 27-30 WARD)

2-FULL NAME Baby Boy Bucher

(a) RESIDENCE NO. 620 S. Para ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Infant |

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year) Feb. 15, 1927

| 8 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | | | 4 | |

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant son

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

10 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER John J. Bucher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Clara Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Plymouth Penna.

14 Informant Clara Bucher

(Address) 620 S. Para.

15 Filed 1927 C. HAMILTON JONES, M. D. Registrar

Per R.C.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 15 . 1927 to Feb. 19 . 1927 that I last saw h living on Feb. 19 . 1927 and that death occurred, on the date stated above, at 11:35 P m.

The CAUSE OF DEATH* was as follows:

Pemphigus neonatorum

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Bacterial Cultures.

(Signed) Margaret B. Ballard M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL University of Md.

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

101-001

**19770** **E 19770**

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 20 Benton Heights ave St. 29 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter H. Schueler

(a) RESIDENCE NO. 20 Benton Heights ave ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred fife yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, ~~Married, Widowed, or Divorced~~, (write the word) |
|---|---|---|
| Male | White | Single |

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 8th 1873

| 7 AGE | Years | Months | Days | If LESS than 1 day, .... hrs. or .... min. |
|---|---|---|---|---|
| | 53 | 7 | 2 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk old
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Louis Schueler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Catherine Berger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs C. O Hossbach
(Address) No 19 W Hamilton ave

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar
By R.L.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5th 1927

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1927, to March 5, 1927, that I last saw him alive on March 5, 1927, and that death occurred, on the date stated above, at 4.15 P. m.

The CAUSE OF DEATH* was as follows:

Lobar-pneumonia (Rt)
(duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis
(duration) 1 yr. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Morris B. Green, M. D.

3/6, 1927 (Address) Hamilton Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ London Park Cemetery — DATE OF BURIAL March 8th 1927

20 UNDERTAKER George Schilling & Sons — ADDRESS 1130 Monument St

Spec—12-23-21—E.B.R.S.—400 lbs.

E 19771

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19771

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1336 Wash Blvd 21-24 Ward)

Registered No.

2-FULL NAME. John S Wheeler

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 1336 W Ostend St 21 Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-CONDITION: Married (Write the word)

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Kate Wheeler

6-DATE OF BIRTH (month, day and year): July 7, 1854

7-AGE. 67 yrs. 8 mos. 2 ds. If LESS than 1 day, ....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Painter

(b) General nature of industry, business, or establishment in which employed (or employer): 050

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Pa

PARENTS.

10-NAME OF FATHER: Adam Wheeler

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Pa

12-MAIDEN NAME OF MOTHER: Mary Long

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Pa

14- (Informant) M. Drabo (Address) 1336 W Ostend St

15- Filed: MAR 7 - 1927 C. HAMPSON JONES, M.D. Registrar

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Mch 5 1927

17- I HEREBY CERTIFY, That I attended deceased from Mch 3 1927 to Mch 5 1927 that I last saw him alive on Mch 4 1927 and that death occurred, on the date stated above, at 8:15 P.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) 2 days

Old Age

CONTRIBUTORY (Secondary)

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) Thos Dillworth M.D.

(Address) 1 New Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cathedral Cem — DATE OF BURIAL: 3/7 1927

20-UNDERTAKER: J. A. Moran — ADDRESS 3009 E. Baltimore

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19772

CERTIFICATE OF DEATH.

12 4h

12 E 19772

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2 Oread Ave. 27-56 Ward)

2-FULL NAME Anna G. Chase

(a) RESIDENCE NO. 2 Oread Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Dr. Charles A. Chase

6 DATE OF BIRTH (month, day, and year): December 17, 1856

7 AGE: Years 70 | Months 2 | Days 18 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): North Yardmouth

(State or country): Maine

PARENTS

10 NAME OF FATHER: Isaac Hayes

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Maine

12 MAIDEN NAME OF MOTHER: Asithuah Batchelor

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Maine

14 Informant: Miss Stella Chase

(Address): 2 Oread Ave.

15 Filed ....., 19..... M. A. Woolston M. Registrar

By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 5th 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb 7th, 1927, to March 5th, 1927,

that I last saw h[illegible] alive on March 4th, 1927,

and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary): Hepatic Congestion.

(duration) 1 yrs. ... mos. ... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm A. Dowell M. D.

3/5, 1927 (Address) 3523 Liberty Hgts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Walnut Hill, Maine — Date of Burial: Mar. 7, 1927

20 UNDERTAKER: Joseph B. Cook — ADDRESS: 1003 W Balto St

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19773

CERTIFICATE OF DEATH.

129 E 19773

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 906 N. Dallas St., 713 Ward)

2-FULL NAME Edith Gatewood

(a) RESIDENCE NO. 906 N. Dallas St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Henry B Gatewood

6 DATE OF BIRTH (month, day, and year): About 09 1892

7 AGE: Years 34; Months ?10; Days ?25; IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Georgia

PARENTS

10 NAME OF FATHER Samuel Keith

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Georgia

12 MAIDEN NAME OF MOTHER Ella Muse

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) S. C.

14 Informant Henry B. Gatewood

(Address) 906 N. Dallas St

15 Filed APR 7 - 1927 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 2 1927, to Mar 4 1927, that I last saw h[illegible] alive on Mar 3 1927, and that death occurred, on the date stated above, at 7:20 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 3 mos. ? ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

3/4, 1927 (Address) 1126 Druid Hill

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Darlington S. C. Date of Burial: Mar 7 1927

20 UNDERTAKER: Robert T. Wilkinson ADDRESS 1515 McCulloh St

Spec.—12-9-25—A Co.—200 Bks.

19774

# HEALTH DEPARTMENT—CITY OF BALTIMORE

74001

## CERTIFICATE OF DEATH.

E 19774

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Russell St. Intown 2572 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia Edwards

(a) RESIDENCE NO. Russell St Intown St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: C

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm Edwards

6 DATE OF BIRTH (month, day, and year): March 27, 1874

7 AGE: Years 52 | Months 11 | Days 6 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER: Henry Johnson

11 BIRTHPLACE OF FATHER (city or town): Md

(State or country)

12 MAIDEN NAME OF MOTHER: Amelia Pickett

13 BIRTHPLACE OF MOTHER (city or town): Md

(State or country)

14 Informant: Husband

(Address): Intown

MAR 7 - 1927

C. HAMPSON JONES, M. D.

By Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/3/ 19 27

17 I HEREBY CERTIFY, That I attended deceased from 2/21/ 19 27, to 3/3/ 19 27.

that I last saw h.. alive on 3/3/ 19 27.

and that death occurred, on the date stated above, at 6.50 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) .....yrs. .....mos. 1 ds.

CONTRIBUTORY (Secondary): Influenza

(duration) .....yrs. .....mos. 9 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J B Hawkins, M. D.

3/4/ 1927 (Address) 712 Eilwood St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery Date of Burial: Mar 7 1927

UNDERTAKER: Robert J Kilian ADDRESS: 1515 McElderry St

Spec.—12-9-25—A Co—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 19775

## CERTIFICATE OF DEATH.

E 19775

REGISTERED NO.

1-PLACE OF DEATH Mercy Hospital

City of BALTIMORE: (No. 13-52 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Riley

(a) RESIDENCE NO. 3905 Falls Rd. Hunt Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Katie Riley

6 DATE OF BIRTH (month, day, and year): January 12- 1849

7 AGE: Years 78 Months 2 Days 24

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Watchman

(b) General nature of industry, business, or establishment in which employed (or employer): Balto. Trust Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

10 NAME OF FATHER: Alexander Riley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Bessie McGuire

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

PARENTS

14 Informant (Address): Mrs. Katie Riley 3905 Falls Road

15 Filed MAR 7 1927 19 C. HAMPSON JONES, M. D. Registrar

Per R K

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 6- 1927

17 I HEREBY CERTIFY, That I attended deceased from March 3 1927, to March 6, 1927, that I last saw h[illegible] alive on March 6, 1927, and that death occurred, on the date stated above, at 5 A.M. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Senility

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. Hurdle, M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Date of Burial March 9- 1927

20 UNDERTAKER: Horace G. Burgee ADDRESS 363 Falls Road

Spec.—8-24-14—M. & T.—2000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19776

## CERTIFICATE OF DEATH.

74-001

E 19776

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3920 Kate Ave ST. 15-63 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Martha J. Baker

(Residence in Baltimore: No. 3920 Kate Ave St.; 40 yrs., mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, or DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Nov. 29, 1843. (Month) (Day) (Year)

7-AGE, 83 yrs. 3 mos. 6 ds. If LESS than 1 day, ....hrs. or.....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work At Home (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country) Frederick Co. Md.

PARENTS.

10-NAME OF FATHER, Alexander J. Beall

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER Caroline Lear

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. F. H. Howard

(Address) 3920 Kate Ave.

15- Filed MAR 7 1927, 191.. C. HAMPSON JONES, M. D. Registrar. Per R.H.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 5, 1927. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar 4 1927, to March 5 1927, that I saw h[illegible] alive on March 5 1927, and that death occurred, on the date stated above, at 1P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Apoplexy).

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis hyper...

(Duration) 10 yrs. mos. ds.

(Signed) Howard H. Warner M. D.

March 7, 1927. (Address) 2604 Garrison Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Chapel Baltimore DATE OF BURIAL, March 7, 1927.

20-UNDERTAKER Horace H. Burgee ADDRESS 3631 Falls Road

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 19777

## CERTIFICATE OF DEATH.

E 19777

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1514 N. Fremont Ave St., 14-20 Ward.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Levinia Lee

(a) RESIDENCE NO. 1514 N. Fremont Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 13, 1926

7 AGE — Years — Months 7 — Days 22 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Milford Lee

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va.

12 MAIDEN NAME OF MOTHER Emma Snyder

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va.

14 Informant Mrs. M. Lee

(Address) 1514 N. Fremont Ave.

Filed APR 7 1927 P. HAMILTON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) .....yrs. .....mos. 7 ds.

CONTRIBUTORY (Secondary) no other history

(duration) .....yrs. .....mos. .....ds.

(Signed) C. J. Pfannenstiel M. D.

(Coroner)

March 4, 1927 (Address) 802 Equitable Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cy Date of Burial March 7 1927

20 UNDERTAKER Leonard Wilson ADDRESS 708 Myrtle Ave

Spec.–7-17-26—A Co.—200 Bks.

# E 19778

## HEALTH DEPARTMENT—CITY OF BALTIMORE

38 N

# E 19778

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 649 Hanover St. 22-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Bonsell

(a) RESIDENCE NO. 649 Hanover St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 Color or Race: Col'd

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Allen Bonsell

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 67 — Months — Days — IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): " 070

(c) Name of employer: "

PARENTS

9 BIRTHPLACE (city or town) (State or country): Md

10 NAME OF FATHER: Wm Hutchinson

11 BIRTHPLACE OF FATHER (City or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Cecelia Pidgeon

(Address): 649 Hanover St

15 Filed ..... 19 ..... C. HAMPSON JONES M. D. Registrar

APR 1 - 1927 Per .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/31 1927

17 I HEREBY CERTIFY, That I attended deceased from 2/8/27 to 3/31/27, that I last saw h alive on 3/31/27, and that death occurred, on the date stated above, at 5.15 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Arterio-Sclerosis (Primary Disease)

(duration) about yrs. 6 mos. da.

18 Where was disease contracted

If not at place of death? none

Did an operation precede death? No Date of

Was there an autopsy? Yes Clinical & Surgical

What test confirmed diagnosis?

(Signed) [illegible] M. D.

3/4/27 (Address) 908 Saint Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

Date of Burial: 3/7/27

20 UNDERTAKER: Mrs G W H Hooper

ADDRESS 406 W Conway St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

(James N. V. Stith) ✓

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19779

E 19779

## CERTIFICATE OF DEATH.

24-001

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 643 N. Pace ST.; 11-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James N. V. Stith

(Residence in Baltimore: No. 643 N. Pace St.; 40 yrs.. mos. da.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, Dec. ? (Month) (Day), 1869 (Year)

7-AGE, 57 yrs. 2 mos. 3 ? ds.

If LESS than 1 day, ....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)..... Hotel

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Frank Stith

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Maria Woodhouse

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Florence Christy (Sister)

(Address) 1120 McCulloh St.

15- MAR 7 1927 C. HAMPSON JONES, M. D. 191.....

Registrar

Per .....

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 4 (Month) (Day), 1927 (Year).

17- I HEREBY CERTIFY, That I attended deceased from March 1 1927, to March 1927, that I saw h[illegible] alive on March 4 1927, and that death occurred, on the date stated above, at 6.35 P m.

The CAUSE OF DEATH* was as follows:

Paralysis Cerebral Hemorrhage

..... (Duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

..... (Duration) ....yrs. ....mos. 4 ds.

(Signed) Charles H. Hancock M. D.

March 6, 1927 (Address) 1128 Mount Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL. Laurel Cemetery

DATE OF BURIAL. Mar. 7, 1927

20-UNDERTAKER J. M. Johnson

ADDRESS 1234 Ething St.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 19780 — 129 — E 19780

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 300 Princeton Pl. Ward 19)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Thomas

(a) RESIDENCE NO. 300 Princeton Pl Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | C. | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) unknown 1868

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| about 57 | 59 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer) 0-37

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Va

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) unknown

14 Informant Elizabeth Thomas

(Address) 300 Princeton Pl

Filed 3-7, 1927 E. HAMPSON JONES, M. D. Registrar

3-7-1927 RK

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1927

17 I HEREBY CERTIFY, That I attended deceased from March 2, 1927, to March 4, 1927, that I last saw h.. alive on March 4, 1927, and that death occurred, on the date stated above, at 5:20 a.m.

The CAUSE OF DEATH* was as follows:

Myocarditis Interstitial Nephritis and Cardiac Failure

(duration) yrs. 2 mos. 2 ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. 2 mos. 2 ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of ... ...

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) G. H. Hall, M. D.

, 19 (Address) 2266 Jerdan

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — Date of Burial 3/7/27

20 UNDERTAKER Mrs. R. A. Elliott — ADDRESS 1745 Ashburton

Spec.—1-10-21—M&T—1500 Bks.

E 19781

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

11-001

E 19781 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1032 Hilmer Alley ST.) 17-24 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Ellen Chase

(a) RESIDENCE NO. 1032 Hilmer Alley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 1870

7 AGE: Years 56 Months 5 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Frederick (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Unknown

14 Informant Comfort L. Chase (Address) 1032 Hilmer Ave

15 Filed ..... 1927 C. HAMILTON JONES, M. D. Registrar

Per R.J.K.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3, 1927

17 I HEREBY CERTIFY, That I attended deceased from 2/28, 1927, to March 3, 1927, that I last saw h[illegible] alive on March 1st, 1927, and that death occurred, on the date stated above, at 1:05 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Les Ellis, M. D.

3/4, 1927 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Lucas

DATE OF BURIAL 3/7, 1927

20 UNDERTAKER: Frank Stansbury

ADDRESS 578 W Baltimore St

Cor.—12-9-25—A Co.—200 Bks. Charles E. Affayroup.

HEALTH DEPARTMENT—CITY OF BALTIMORE

185

19782

CERTIFICATE OF DEATH.

E 19782
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 7-13 (Ward))

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Affayvaroup

(a) RESIDENCE NO. 1212 Old Bmr St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of): Hannah Affayvaroup

6 DATE OF BIRTH (month, day, and year): Oct. 20. 1867

7 AGE: Years 59 Months 4 Days 13 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): O'S
(c) Name of employer

9 BIRTHPLACE (city or town): Balto
(State or country)

PARENTS

10 NAME OF FATHER: Jno Affayvaroup

11 BIRTHPLACE OF FATHER (city or town): Balto
(State or country)

12 MAIDEN NAME OF MOTHER: Mary Watt

13 BIRTHPLACE OF MOTHER (city or town): Washington DC
(State or country)

14 Informant: Mr Affayvaroup
(Address): 1212 N Bmr

Filed MAR 7 - 1922 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 3 192-7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner)

March 3-, 1924 (Address) 1039 Druid

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. State In the City yrs., 59 mos., 4 ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery Date of Burial March 6 1924

20 UNDERTAKER: William G Schaefer ADDRESS 816 Fremont

c.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

19783 | REGISTERED NO. E 19783

1-PLACE OF DEATH

ITY OF BALTIMORE: (No. St Agnes Hospital ST. 25-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Neil Richardson

(a) RESIDENCE NO. 1131 6th Avenue ST., Huntington W.Va WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | married |

If married, widowed or divorced HUSBAND of (or) WIFE of Lillian Richardson

DATE OF BIRTH (month, day, and year) June 22, 1871

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 52 | 10 | 14 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fire Insurance Ad'j

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

BIRTHPLACE (city or town) (State or country) Canada.

PARENTS

10 NAME OF FATHER not given

11 BIRTHPLACE OF FATHER (city or town) (State or country) " "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant Mrs Vergain Richardson (Address) 1131 6th Ave Huntington W. Va

15 Filed 3 7, 1927 C. HAMPSON JONES Registrar KJL

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-6 1927

17 I HEREBY CERTIFY, That I attended deceased from 2-25, 1927, to 3-6, 1927.

that I last saw him alive on 3-6, 1927.

and that death occurred, on the date stated above, at 2.40 a. m.

The CAUSE OF DEATH* was as follows: Cardiac insufficiency.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma stomach inoperable (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 2-26-27

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) J. Theron Hunter M. D.

3-6 1927 (Address) St. Agnes' Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Huntington, W. Va

DATE OF BURIAL 3/7 1927

ADDRESS 502 E 4th St.

20 UNDERTAKER Von Cook

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

19784 — 100-001

19784

REGISTERED NO.

1-PLACE OF DEATH
City of BALTIMORE: (No. 5017 Beaufort St. 24-56 Ward)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Penney Gray

(a) RESIDENCE NO. 5017 Beaufort St. Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 Color or Race: White
5 Single, Married, Widowed, or Divorced, (write the word): Widowed
5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of: Edward M =
6 DATE OF BIRTH (month, day, and year): Oct - 15 1839
7 AGE: Years 87 Months 4 Days 21 IF LESS than 1 day.....hrs. or.....min.
8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:
9 BIRTHPLACE (city or town): Philadelphia
(State or country):

PARENTS
10 NAME OF FATHER: Tyler English
11 BIRTHPLACE OF FATHER (city or town): unknown
(State or country):
12 MAIDEN NAME OF MOTHER: unknown
13 BIRTHPLACE OF MOTHER (city or town): unknown
(State or country):

14 Informant: James E. Horn
(Address) 5017 Beaufort Ave

16 Filed ..... 19 ..... C. HAMPTON JONES, M. D. Registrar
JAN 7 1927 KH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 6 19 27

17 I HEREBY CERTIFY, That I attended deceased from Mch 1, 1927, to Mch 5, 1927, that I last saw h[e] alive on Mch 5 1927 and that death occurred, on the date stated above, at 1355 m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ..... yrs. ..... mos. 3 ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted —
If not at place of death? —
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) Charles L Wells, M. D.
, 19 (Address) 5242 York Rd City

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Philadelphia Date of Burial 1/8 1927
20 UNDERTAKER: Wm Cook ADDRESS 502 E North Ave

Spec.-7-17-26—A Co.—200 Blks.

Fralings 682 Mass Ave 100-00

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

19785

REGISTERED NO. E 19785

1-PLACE OF DEATH

City of BALTIMORE: (No. 735 Mc Henry St. 21-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma H Adams

(a) RESIDENCE NO. 735 Mc Henry St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| F | W. | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward F Adams

6 DATE OF BIRTH (month, day, and year) July 1856

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 70 | 8 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home - 37

(b) General natore of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md

PARENTS

10 NAME OF FATHER Frederick Browning

11 BIRTHPLACE OF FATHER (City or town) Balto

(State or country) Md

12 MAIDEN NAME OF MOTHER Eliz Corney

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md

14 Informant Edward H Adams

(Address) 735 Mc Henry St

Filed MAR 7 - 1927. HAMPTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5 1927

17 I HEREBY CERTIFY, That I attended deceased from Feby 15 1927 to March 5 1927

that I last saw h[illegible] alive on March 4 1927

and that death occurred, on the date stated above, at 10:10 A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Arteriio

(duration) yrs. 6 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinic se

(Signed) M C Finlinger M. D.

4/7: 1927 (Address) 182 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Date of Burial Mar 9 1927

20 UNDERTAKER H C Cook ADDRESS [illegible]

...—1-12-23—M&T—500 Blks.

v 6 8 0

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 19786

E 19786
1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. JOHNS HOPKINS HOS ST. WARD)

REGISTERED NO. 22-3349

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry M. Moore

(a) RESIDENCE NO. 235 E. Church St (If non resident give city or town and State) Frederick Md

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

6 If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE of~~

DATE OF BIRTH (month, day, and year) Unknown.

| AGE | Years | Months | Days | If LESS than 1 day, hrs or min |
|---|---|---|---|---|
| | 56 | | | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Flagman B. & O. R. R.

(b) General nature of industry, business, or establishment in which employed (or employer) 073

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. Va.

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) unk

12 MAIDEN NAME OF MOTHER unk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unk

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 3 - 1927 19 C. HAMILTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 28, 1927, to March 6 1927, that I last saw him alive on March 6 1927, and that death occurred, on the date stated above, at 4.40 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Lobar Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Carcinoma of prostate

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not Home.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) H. C. Smith, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Charlestown, W. Va.

DATE OF BURIAL March 10 1927

ADDRESS

20 UNDERTAKER P. H. R. Etchison & Son, Frederick Md.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 19787

REGISTERED NO. E 19787

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1744 Eastern Ave. St.) 2-4 (Ward)

2-FULL NAME William J. Knowles

(a) RESIDENCE NO. 1744 Eastern Ave. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sallie Knowles

6 DATE OF BIRTH (month, day, and year): April 24 1848

7 AGE: Years 78 | Months 8 | Days 10 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Sea. [illegible]

(b) General nature of industry, business, or establishment in which employed (or employer): Captain of

(c) Name of employer

9 BIRTHPLACE (city or town): Delaware

(State or country)

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town): " "

(State or country)

12 MAIDEN NAME OF MOTHER: "

13 BIRTHPLACE OF MOTHER (city or town): "

(State or country)

14 Informant: Mrs Sallie Knowles

(Address) 1744 Eastern Ave

15 Filed [illegible] 1927 C. HAMPTON JONES, M. D. Registrar

MAR 7 - 1927

By [illegible]

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 6 19 27

17 I HEREBY CERTIFY, That I attended deceased from May 2 19 26, to March 5 19 27,

that I last saw h[illegible] alive on March 5 19 27,

and that death occurred, on the date stated above, at 4 A M.

The CAUSE OF DEATH* was as follows:

Germinal Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic myocarditis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? S. S. & S.

(Signed) John J. Kruger, M. D.

, 19 (Address) 2627 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sharptown Md. Date of Burial 3-7th 19 27

20 UNDERTAKER: N. D. Graves & Son ADDRESS Sharptown Md.

...—1-12-23—M&T—500 Bks.

9788

# HEALTH DEPARTMENT—CITY OF BALTIMORE

161-002

## CERTIFICATE OF DEATH.

REGISTERED No. 9788

1-PLACE OF DEATH St Joseph's Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE; (No. Caroline & Oliver ST., 7 WARD)

2-FULL NAME Peter Kelly.

(a) RESIDENCE No. 273 S. Robinson ST., 9 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | — |

If married, widowed, or divorced HUSBAND of (or) WIFE of —

DATE OF BIRTH (month, day, and year) Feb 25, 1847.

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | — | — | 9 41 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer and

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) St Josephs Hosp

10 NAME OF FATHER Peter Joseph Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore md.

12 MAIDEN NAME OF MOTHER Mary Trent Tennison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Peter J. Kelly.

(Address) 273 S. Robinson St.

15 Filed 1927, 19). HAMILTON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/6/27 1927

17 I HEREBY CERTIFY, That I attended deceased from 2/25, 1927, to 3/6/27, 1927.

that I last saw h/m alive on 3/6/27, 1927

and that death occurred, on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? yes Central

What test confirmed diagnosis? Clinical & autopsy

(Signed) Frank L. Hamm, M. D.

Mar. 6, 1927 (Address) 1300 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL Mch 7 1927

20 UNDERTAKER Lilly & Zeiler

ADDRESS 4038 Woodland

Spec.—1-10-21—M&T—1500 Blks.

E 19789

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19789

## CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1721 E Eager ST., 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Alice MacKentyre, MacIntyre

(a) RESIDENCE NO. 1721 E Eager st ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | white | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James MacIntyre

6 DATE OF BIRTH (month, day, and year) Feb 1861

| ✦AGE Years | Months | Days | If LESS than 1 day, ....hrs or ....min. |
|---|---|---|---|
| 66 | 1 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Saml. Donnelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Donnelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. J. Herbert

(Address) 1641 Eutaw Av

15 Filed 1927 19 C. HAMPSON JONES, M. D. Registrar

Per RR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8 1927

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1927, to March 6, 1927, that I last saw her alive on March 5, 1927, and that death occurred, on the date stated above, at 7 15 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

and Paralysis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thomas [illegible] M. D.

, 19 (Address) 1025 N Wolfe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

DATE OF BURIAL Mar 8" 1927

20 UNDERTAKER Geo M. Smith & Son

ADDRESS 811 W Lex

c.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19790

## CERTIFICATE OF DEATH.

129

E 19790

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Josephs Hospital

ITY OF BALTIMORE: (No. Caroline & Oliver St. 8-45 WARD)

2-FULL NAME William Stevens

(a) RESIDENCE NO. 1681 Cliftview ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married. |

If married, widowed, or divorced, HUSBAND of (or) WIFE of Jennie Stevens

DATE OF BIRTH (month, day, and year) June 1857

| AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 70 | 2 | | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maine.

PARENTS

10 NAME OF FATHER Wm Stevens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maine.

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs Jennie Stevens

(Address) 1681 Cliftview Ave

15 Filed MAR 7 - 1927 H. A. BOYD JONES, M. D. Registrar

By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5 1927

17 I HEREBY CERTIFY, That I attended deceased from March 3, 1927, to March 5, 1927, that I last saw him alive on March 5, 1927, and that death occurred, on the date stated above, at 5:45a m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis. Chr. Nephritis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) Clement R. Thomas, M. D.

, 19 (Address) St Josephs Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Balto Co. | Mar 8th 1927 |
| 20 UNDERTAKER | ADDRESS |
| Geo M Smith & Son | 814 N Mott. |

—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

19791

## CERTIFICATE OF DEATH

E 19791

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 817 S. Third ST. 26-V WARD)

2-FULL NAME Selma A. Ritter

(a) RESIDENCE NO. 817 S. Third ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

If married, widowed, or divorced
HUSBAND of (or) WIFE of Louis Ritter

DATE OF BIRTH (month, day, and year) Sept. 18-1863

| AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 63 | 5 | 16 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER J. Feidler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) not known

14 Informant Fred. Ritter
(Address) 817 S. Third St

15 Filed ..... C. HAMPSON JONES, M. D. Registrar

R 7 - 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1927, to March 6, 1927, that I last saw h-er alive on March 5, 1927 and that death occurred, on the date stated above, at 2 60 A1 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) Gradual yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation + X ray

(Signed) Horace B[illegible]stow M. D.

3/7, 1927 Address 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Oak Lawn Cemetery | March 9 1927 |
| 20 UNDERTAKER | ADDRESS |
| Zirkler & Zirkler | 1739 E. Eager st |

pec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19792

## CERTIFICATE OF DEATH.

100-00

E 19792

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 47 E. Cross St. 2333

2-FULL NAME Joseph H. Allen

(a) RESIDENCE NO. 47 E Cross St. Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Allen

6 DATE OF BIRTH (month, day, and year) Jan 13 1858

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 69 | 0 | 22 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Cecelia Dunning

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto Md

14 Informant Annie Allen

(Address) 47 E Cross St.

15 Filed ..... 1927 H. HAMPSON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5 1927

17 I HEREBY CERTIFY, That I attended deceased from Feby 28 1927, to March 5, 1927,

that I last saw him alive on March 5, 1927,

and that death occurred, on the date stated above, at 3.40 p m.

The CAUSE OF DEATH* was as follows:

old age

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) ..... yrs. ..... mos. 1 ..... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Edw Smith M. D.

(Address) 910 Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters Cem Date of Burial: June 8 1927

20 UNDERTAKER: N M Rouleau ADDRESS: 2238 N Mott

HEALTH DEPARTMENT—CITY OF BALTIMORE

# CERTIFICATE OF DEATH.

E 19793
REGISTERED NO.

E 19793
1 PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals 17-51 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eugene Ward Murphy

(a) RESIDENCE NO. 2730 Maryland Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. 10 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) April 15 - 1887

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 39 | 10 | 23 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tinner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Owen J. Murphy
11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland
12 MAIDEN NAME OF MOTHER Mary V. Dolan
13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Hospital Records
(Address)

Filed ..... 19 ..... Registrar

MAR 7 - 1927

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5 1927

17
I HEREBY CERTIFY, That I attended deceased from February 19 1927, to March 5, 1927, that I last saw him alive on March 5, 1927, and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

unknown (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) none

none (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted
If not at place of death? unknown
Did an operation precede death? No Date of none
Was there an autopsy? Yes
What test confirmed diagnosis? Clinical findings and autopsy
(Signed) W. E. Gatteus M. D.
, 19 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — Date of Burial Mar 8 1927

20 UNDERTAKER John J. Fields — ADDRESS 1200 N Lambard

C. HAMPSON JONES, M. D.

OF DEATH. See instructions very important.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19794

## CERTIFICATE OF DEATH.

100-801

E 19794

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 614 W. Biddle St. St. 11-15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Junius W. Tillman

(a) RESIDENCE NO. 614 W. Biddle St. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug. 10, 1925.

7 AGE: Years 1 Months 6 Days 24 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER James Tillman

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va.

12 MAIDEN NAME OF MOTHER Susan Brown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va.

14 Informant Susan Brown Tillman

(Address) 614 Biddle St.

15 Filed ..... 19 ..... Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest

(Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said inquest

(Inquest, autopsy or inquiry.) jury find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) .....yrs. .....mos. 4 ds.

CONTRIBUTORY (Secondary) no other cause

(duration) .....yrs. .....mos. .....ds.

(Signed) J. J. Hanson, M. D.

(Coroner)

March, 1927 (Address) 2832 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Date of Burial March 7 1927

20 UNDERTAKER: Daniel Easton ADDRESS 916 Cane

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 19795 — REGISTERED NO. E 19795

1-PLACE OF DEATH

City of BALTIMORE: (No. 1402 N. Mosher St. 15-21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Irene Miller

(a) RESIDENCE NO. 1402 N. Mosher St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | colored | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hubsonam

6 DATE OF BIRTH (month, day, and year) about 1895

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 32 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Va.

PARENTS

10 NAME OF FATHER Wm Harrison

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va.

12 MAIDEN NAME OF MOTHER Carrie Brand

13 BIRTHPLACE OF MOTHER (city or town) Va

(State or country)

14 Informant Lula Martin

(Address) 1402 N. Mosher St.

15 Filed 1-1927 19 C. HAMPSON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma of Ovary

(daration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) no other history

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.

(Coroner)

March 7 1927 (Address) 28 Redwood St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Date of Burial March 7 1927

20 UNDERTAKER Daniel Easton ADDRESS 716 Eden

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

100-001

E 19796 REGISTERED DEATH

E 19796

City of BALTIMORE: (No. Johns Hopkins Hospital St., 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Calvert K. Johnson

(a) RESIDENCE NO. 1244 McElderry St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | col | single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 27/27

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | | 1 | 6 8 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md

PARENTS

10 NAME OF FATHER Harry Johnson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto, Md

12 MAIDEN NAME OF MOTHER Olivia William

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) N.C.

14 Informant Harry Johnson
(Address) 1244 McElderry St

15 Filed 3-7 1927 C. HAMPSON JONES, M. D. Registrar
Per R M

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 5/27 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Lobular Pneumonia-(both lungs)
with abcesses.
(Autopsy at Hopkins)
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) J. H. Falls M. D.
(Coroner)

3/6/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem Date of Burial 3-7 1927

20 UNDERTAKER Jas. Inc. Skinner ADDRESS 1655 E. Broadst

ec.—1-12-23—M&T—500 Blks.

~~19796~~ 19797

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 19797

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL (Street) 16-23 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Tucker Finney

(a) RESIDENCE NO. 720 N. Carey ST. WARD Birdsnest Va
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. 9 mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX: male

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced: (write the word) Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year) 1907

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 20 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lunch Room Waiter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Virginia

10 NAME OF FATHER Alfred Finney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Nora Bowers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Records

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar Per RCS

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 5 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 3, 1927, to Mar 5 1927, that I last saw h[illegible] alive on Mar 5, 1927 and that death occurred, on the date stated above, at 11.20 a.m.

The CAUSE OF DEATH* was as follows:

Appendicitis Acute

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Mar 3 1927

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) Henry C. Jelmen, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Zion — DATE OF BURIAL 3-7 1927

20 UNDERTAKER Joseph A Lively — ADDRESS 409 N Mount St

Cor.—1-12-23—M&T—100 Bks.

19798

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19798

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 460 Ho St 3-4 WARD)

REGISTERED NO. 66

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Rand

(a) RESIDENCE NO. 460 Ho St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| M | C | Mar- |

If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

DATE OF BIRTH (month, day, and year)

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 60 yrs- | | | |

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Informant
(Address)

Filed - 1927 C. HAMPSON JONES, M. D.

By ARA Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 21 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Contributory (duration) Yrs. mos 7 ds.

(Secondary) Cystitis (duration) Yrs. mos. 1 ds.

Feb 21 192 (Address) 460 Hollins St. M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| 20 UNDERTAKER | ADDRESS |

UNIVERSITY OF MARYLAND
Commissioner Health

Cor.—12-9-25—A Co.—200 Bks.

E 19799

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 19799

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Fallsway near Lanvale Ward)

2-FULL NAME

(a) RESIDENCE NO. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1897

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 30 ? | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant

(Address)

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 26. 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest and Autopsy (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract. Skull
Fall or Jumped from City Court Bldg

Contributory (Secondary) yrs. mos. ds.

Signed: (Coroner) M. D.

Mch 5, 1927 (Address) 1659 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial MAR 7 - 1927

20 UNDERTAKER — ADDRESS

UNIVERSITY OF MARYLAND

Commissioner Health

Per. Sec.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19800

## CERTIFICATE OF DEATH.

129 E 19800

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. City Jail St. 21-31 Ward)

2-FULL NAME Edward Washington

(a) RESIDENCE NO. 602 S. Eutaw St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | Col | ? |

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 43 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant

(Address) C. HAMPSON JONES, M. D.

15 Filed 19 Per Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 2-3 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Influenza

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac

(duration) yrs. mos. ds.

(Signed) H. J. Pelouze M. D.

(Coroner)

Mch 5, 1927 (Address) 1634 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 19

20 UNDERTAKER ADDRESS

Commissioner Health.

UNIVERSITY OF MARYLAND. MAR 7 - 1927

Spec.—12-9-25—A Co.—200 Bks.

E 19801

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 19801

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS 16

City of BALTIMORE: (No. [redacted] St. 16 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gustav Milgt

(a) RESIDENCE NO. 872 W. Fayette St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widowed |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1871

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 56 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Ferdinand Milgt

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Julia —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant

(Address) Records

BALTIMORE CITY HOSPITALS

15 Filed 1927 19

C. HAMPSON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 27 1927

17

I HEREBY CERTIFY, That I attended deceased from February 23, 1927, to February 27, 1927, that I last saw him alive on February 27, 1927, and that death occurred, on the date stated above, at 11:20 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Myocardial failure.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? gross & laboratory

(Signed) R Hooper Lunt, M. D.

And (18) (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

UNIVERSITY OF MARYLAND MAR 7 1927

20 UNDERTAKER — ADDRESS

Commissioner Health.

Cor.—12-9-25—A Co.—200 Bks.

E.19802

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19802

## CERTIFICATE OF DEATH.

100-09

REGISTERED NO. _____

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1129 Wilmot Alley St. 17-2 Ward)

2-FULL NAME Margaret Tillman

(a) RESIDENCE NO. 1129 Wilmot Alley St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): about 1887

7 AGE: Years: 39 Months: Days: If LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 070
(c) Name of employer

9 BIRTHPLACE (city or town): _____
(State or country): Md.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town): _____
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town): _____
(State or country)

14 Informant: Northwestern Police Dist
(Address) Penna Ave

15 Filed _____, 19 _____ Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 25 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) _____

(duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.
(Coroner)

Mar 5 1927 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL: _____ Date of Burial Mar 7 1927

20 UNDERTAKER: _____ ADDRESS: _____

Commissioner Health

UNIVERSITY OF MARYLAND. MAR 7 - 1927

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19803

## CERTIFICATE OF DEATH.

113

E 19803

1-PLACE OF DEATH

City of BALTIMORE: (No. 710 Woodyear St. St. 16-23 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Vaughan

(a) RESIDENCE NO. 710 Woodyear St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | colored | single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 1925

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 1 | 4 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9 BIRTHPLACE (city or town).....

(State or country) Md.

PARENTS

10 NAME OF FATHER James Vaughan

11 BIRTHPLACE OF FATHER (city or town).....

(State or country) Md.

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town).....

(State or country) Md.

14 Informant Mrs. James Vaughan

(Address) 710 Woodyear St.

15 Filed.....19.....

Registrar

114 27 P. MORGUE.

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Bronch-Pneumonia

(duration) yrs. mos. 2 ds.

(Signed) J. T. Hennessy M. D.

(Coroner)

19 27 (Address) 202 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL University of Maryland Date of Burial MAR 7 -19 1927

20 UNDERTAKER C. HAMPSON JONES M. D. ADDRESS Commissioner Health

Per Wm. E. Woodall

E 19804

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 19804

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1647 E. Fayette 6-9 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cora Williams

(Residence in Baltimore: No. 1647 E. Fayette St.; yrs., mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

| 3-SEX | 4-COLOR OR RACE | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) |
|---|---|---|
| female | col | |

6-DATE OF BIRTH, Feb 19/27, 1
(Month) (Day) (Year)

7-AGE, 18 yrs. mos. 16 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) HD

9-BIRTHPLACE, (State or Country), Balto., Md.

PARENTS.

10-NAME OF FATHER, Leslie Williams

11-BIRTHPLACE OF FATHER (State or Country), N.C.

12-MAIDEN NAME OF MOTHER Julia Dunnington

13-BIRTHPLACE OF MOTHER (State or Country), N.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leslie Wiliams

(Address) 1647 E. Fayette St.

15-

Filed ..... 191 ..... C. HAMPSON JONES, M. D. Registrar.

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 7/27, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Prematurity

(Reported 8 mons. gestation.)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Pullen M. D.
(Coroner.)

3/7, 191... (Address) 508 N. North Av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITAL

DATE OF BURIAL, ....., 19....

20-UNDERTAKER

ADDRESS

Commissioner of Health.

MAR 7 - 1927

per Wm. H. WOODALL

Spec.—12-9-25—A Co.—200 Pds.

E 19805

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 19805

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St., 21-24 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Caodskac CIDEIKIS

(a) RESIDENCE NO. 6534 LOMBARD STREET St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? 19 yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1891

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 36 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Lithuania

PARENTS

10 NAME OF FATHER Tony Petroiaski

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Lithuania

12 MAIDEN NAME OF MOTHER Barbe —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Lithuania

14 Informant BALTIMORE CITY HOSPITALS

(Address) Records

15 Filed ..... 19 ..... Registrar

1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5 1927

17

I HEREBY CERTIFY, That I attended deceased from March 2, 1927, to March 5, 1927, that I last saw h.. alive on March 5, 1927, and that death occurred, on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. ? ds.

CONTRIBUTORY

(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Laboratory

(Signed) R Cooper Leavitt, M. D.

March 5 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Holy Redeemer — March 8, 1927

20 UNDERTAKER — ADDRESS

John Grebliauckas — 423 S Paca St.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19806 E 19806

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Found floating in the water off

City of BALTIMORE: (No. Fort Armstead. St. 25-7 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Unknown.

(a) RESIDENCE NO. Do not know. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 Color or Race: Yellow.

5 Single, Married, Widowed, or Divorced, (write the word): Do not know.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: --------

6 DATE OF BIRTH (month, day, and year): Do not know.

7 AGE: Years: about 35 Months: -------- Days: -------- IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Do not know.

(b) General nature of industry, business, or establishment in which employed (or employer): 087

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) apparently Japan.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Do not know.

14 Informant Police Report. S.D.

(Address) C. HAMPSON JONES, M. D.

1927 Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Found February 28, 1927 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.
probably accidental.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

(duration) .....yrs. .....mos. .....ds.

(Signed) Otto M. Bernhardt M. D.
(Coroner)

8/5, 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death .....yrs., .....mos., .....ds. In the State .....yrs., .....mos., .....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY Date of Burial MAR 7 - 1927

20 UNDERTAKER Commissioner Health ADDRESS

Filed ..... Per ..... 19

THE MORGUE

Per. Wm. E. WOMRATH

Cor.—12-9-25—A Co.—200 Blks.

E 19807

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

18 E 19807

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Found floating in the water at the Foot of Hull St., St., 24-33 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Unknown,

(a) RESIDENCE NO. Do not know. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male. | White. | Do not know. |

3a If married, widowed, or divorced HUSBAND of (or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) Do not know.

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| about 45 | --------- | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Do not know.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Do not know.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Do not know.

14 Informant Police Report, S.D.

(Address)

15 1927 C. HAMPSON JONES, M. D.

Per _____ Registrar

THE MORGUE

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Found February 24, 1927 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.
probably accidental.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

(duration) .....yrs. .....mos. .....ds.

(Signed) Otto M. Steinhardt M. D.
(Coroner)

8/5, 1927 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY Date of Burial MAR 7 - 1927 19

20 UNDERTAKER ADDRESS

Commissioner Health.

Per Wm. E. Tyndall

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19808

E 19808

## CERTIFICATE OF DEATH.

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2107 McHenry St. _____ Ward) 70-69

2-FULL NAME Emmett N. Gosnell

(a) RESIDENCE NO. 2107 McHenry St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widower |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 28th 1867

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 59 | 9 | 7 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cooper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER Moses Gosnell

11 BIRTHPLACE OF FATHER (city or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Roxana Covey

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant N. E. Gosnell

(Address) 1922 Wilkens ave

15 Filed C. HAMPSON JONES, M. D.

1927 Per _____ Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, au-topsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 2 hrs. — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

(Signed) Thos. B. Hutton M. D.

(Coroner)

March 6 1927 (Address) Curtis Bay, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. John's Cemetery Ellicott City Md Date of Burial 3/8 1927

20 UNDERTAKER Harry A. Welsh ADDRESS 1531 W Lanvale

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

19809 E 19809

## CERTIFICATE OF DEATH.

90-69 11-00

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 422 Millington Lane, (ST.) (WARD)

2-FULL NAME Mollie E Westaway.

(a) RESIDENCE NO. 422 Millington Lane ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Late John Westaway

6 DATE OF BIRTH (month, day, and year) June 26, 1863

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs. or ....min. |
|---|---|---|---|---|
| | 64 | 8 | 7 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Samuel Long

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Amos

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Thresa N. Mathis
(Address) 422 Millington Lane

15 - 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 5 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 12 1927 to Mar 5 1927.
that I last saw her alive on Mar. 5 1927.
and that death occurred, on the date stated above, at 3 p. m.
The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) ... yrs. mos 17 ds.

CONTRIBUTORY (Secondary) Grippe

(duration) ... yrs. ... mos. 4 ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? P.E.

(Signed) Homer L. Ford M. D.
3/7, 1927 (Address) 735 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pleasant Grove Cemetery — DATE OF BURIAL Mar. 8 1927

20 UNDERTAKER Harry H. Nitzke — ADDRESS 1531 N Fulton Ave

TION is very important. See instructions on back.

7

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19810

CERTIFICATE OF DEATH.

101-001

E 19810

1-PLACE OF DEATH

City of BALTIMORE: (No. 1725 Lamont Avenue St., 9-18 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James J. Klarman

(a) RESIDENCE NO. 1725 Lamont Avenue St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widower |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Catherine Klarman

6 DATE OF BIRTH (month, day, and year) Nov.29,1849

| 7 AGE Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|
| 77 | 3 | 5 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Greenmount Cemetery

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Sabastian Klarman

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore, Md.

14 Informant Margaret Klarman
(Address) 1725 Lamont Avenue

15 C. HAMPSON JONES, M. D.
1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (Month, day, and year) 3/6 1927

17

I HEREBY CERTIFY, That I attended deceased from Mch 2, 1927, to Mch 6, 1927, that I last saw him alive on Mch 6, 1927, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Clyde, M. D.

3/7, 1927 (Address) 1160 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — Date of Burial: 3/8/1927

20 UNDERTAKER: George J. Ruth — ADDRESS: 1735 HARFORD AV

Spec.—1-10-21—M&T—1500 Bks.

Dr. Glassman. 1926 69

E 19811

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19811

## CERTIFICATE OF DEATH.

100-0

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 141 Wilkins ST. 70 92 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick C. Lerch

(a) RESIDENCE NO. 141 Wilkins St ST. 20th WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? 50 yrs. mos. — ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Caroline W. Lerch

6 DATE OF BIRTH (month, day, and year): May 1st 1857

7 AGE: Years 69 Months 4 Days 27 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Butcher 013

(b) General nature of industry, business, or establishment in which employed (or employer): John Frederick

(c) Name of employer: 112 Shiron St.

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Frederick C. Lerch

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Wilkinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Caroline W. Lerch (Address) 141 Wilkins St

15 Filed 1927 19 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 5th 27

17 I HEREBY CERTIFY, That I attended deceased from Feb 20 1927 to Mar 5 1927 that I last saw him alive on Mar 5 1927 and that death occurred, on the date stated above, at 11.50 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

Myocarditis

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary): Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Glassman M. D.

Mar 7 1927 (Address) 20 E. Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westegun Cemetery — DATE OF BURIAL: Mar 8th 1927

UNDERTAKER: F. B. Wiseburst — ADDRESS: 1850 W. Baltimore St

ec.—1-12-23—M&T—500 Bks.

19812

# HEALTH DEPARTMENT—CITY OF BALTIMORE

19812

## CERTIFICATE OF DEATH.

11-603

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mt Hope Retreat ST. (WARD) 28-63

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Eigenbrodt

(a) RESIDENCE NO. Mt Hope Retreat ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 18 1859

7 AGE: Years 67 | Months 8 | Days 19 | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER H L Eigenbrodt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Minnie Christopher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mt Hope Friends Mt Hope Retreat.

15 Filed 1927 Per C. HAMPSON JONES, M. D. Registrar Reed.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1925, to March 6, 1927.

that I last saw h alive on March 6, 1927

and that death occurred, on the date stated above, at 6.10 P. M.

The CAUSE OF DEATH was as follows:

Influenza.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fatty Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Milton P. Ibell, M. D.

, 19 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: March 9 1927

20 UNDERTAKER: Mrs. Mrs. John W. Teufel & Son — ADDRESS: 801 W. Fayette

Rec— 12-23-21—E.B.R.S.—400 Bks.

E 19813

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19813

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1701 Scott St., 21 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Kathrine Fisher

(a) Residence No. 1701 Scott St., 21 Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. white

5-CONDITION. (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John W Fisher

6-DATE OF BIRTH (month, day and year) Aug 24 1863

7-AGE. 63 6 11 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED.

(a) Trade, profession, or particular kind of work. Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Henry Buchheim

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country).

14-(Informant) Mrs W Fisher

(Address) 1701 Scott St

15-Filed in 1927 C. HAMPSON JONES, M. D. Registrar.

Per

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 5 27

I HEREBY CERTIFY, That I attended deceased from Feb 27 27 to March 5 27

That I last saw h alive on March 5 27

And that death occurred, on the date stated above, at 11 30 A.M.

The CAUSE OF DEATH* was as follows:

1 Bronchial pneumonia

(Duration) 5 ds

CONTRIBUTORY (Secondary) Fract. of L. Femur

(Duration) yrs. 3 mos. 8 ds

18-Where was disease contracted if not at place of death? Canton Hosp.

Did an operation precede death? No

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John G. Schwarzenberg M.D.

(Address) 8 New Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park

DATE OF BURIAL. Mar 8 1927

20-UNDERTAKER. Mrs. Nes. John W. Fairfield & Son

ADDRESS 801 W. Fayette St

Spec.—12-8-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

9814 — E 19814 — 129

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 803 Scott St. 21-29 Ward)

2-FULL NAME Mary A. Spetta.

(a) RESIDENCE NO. 803 Scott St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. 8 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Michael Spetta

6 DATE OF BIRTH (month, day, and year) June 5 1867

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 59 | 8 | 27 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Cook

(b) General nature of industry, business, or establishment in which employed (or employer) Restaurant Keeper

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Maryland.

PARENTS

10 NAME OF FATHER Michael Hodges

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Ireland.

12 MAIDEN NAME OF MOTHER Ellen Dundon

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Ireland.

14 Informant William Hodges

(Address) 803 Scott St

15 Filed _____, 19 _____ C. HAMPSON JONES, M. D. Registrar

1927 By _____

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-4th 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb-10, 1927, to March 4, 1927, that I last saw h.. alive on March 4, 1927, and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) ? yrs. 1 mos. 4 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. 9 ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of ~

Was there an autopsy? No

What test confirmed diagnosis? P. E.

(Signed) Lewis Kirkwood M. D.

3/7 1927 (Address) 930 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem. Date of Burial 3-8 1927

20 UNDERTAKER C. T. Hartle ADDRESS 1156 West St

—1-12-23—M&T—100 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

19815 E 19815

## CERTIFICATE OF DEATH.

REGISTERED NO. 1170

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

Y OF BALTIMORE: (No. 2041 Calvert ST. 12-50 WARD)

2-FULL NAME John A. Clarence

(a) RESIDENCE NO 2041 N. Calvert ST., 12 WARD

(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

married, widowed, or divorced HUSBAND of (or) WIFE of Helen F. Clarence

TE OF BIRTH (month, day, and year) Oct 17 1862

| E | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 64 | 4 | 16 | |

CUPATION OF DECEASED
) Trade, profession or articular kind of work: Dentist
) General nature of industry, usiness, or establishment in hich employed (or employer)
) Name of employer

RTHPLACE (city or town) State or country): Louisianna

NAME OF FATHER John Joseph Clarence

BIRTHPLACE OF FATHER (city or town) (State or country): France

2 MAIDEN NAME OF MOTHER Sophinie Blondin

3 BIRTHPLACE OF MOTHER (city or town) (State or country): Louisianna

Informant: Mrs Helen F. Clarence

(Address) 2041 N Calvert

Fil 1927 C. HAMPSON JONES, M. D. Registrar

Per [redacted]

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/5 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Gun Shot wound through head (Suicidal)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) John H. Morrison, M. D. (Coroner)

3/7, 1927 (Address) 532 Roland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: [redacted] London Park Cem

DATE OF BURIAL: Mch 8 1927

20 UNDERTAKER: Jos Sourbeer's Son

ADDRESS: 217 S. Pa...

Spec.—1-10-21—M&T—1500 Bks.

(Sharff)

19816

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19316

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Gen. Hosp. St. 28-63 WARD) 118

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catharine Sharff

(a) RESIDENCE NO. Backs Lane & Marston Road ST., WARD (Mercer Co.)

(Usual place of abode)

Length of residence in city or town where death occurred 45 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Fem | White | married - |

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of E F Sharff

6 DATE OF BIRTH (month, day, and year) Apr. 17, 1880

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs. or min. |
|---|---|---|---|---|
| | 46 | 10 | 17 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Belair (State or country) Maryland -

PARENTS

10 NAME OF FATHER Thomas Snowden

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Morgan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Hospital Record. (Address)

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per ACH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 6 1927

17

I HEREBY CERTIFY, That I attended deceased from 2/25/27, 19 , to 3/6 , 1927, that I last saw her alive on 3/6 , 1927, and that death occurred, on the date stated above, at 12 56 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Pelvic inflammatory disease.

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Intestinal obs. pulmonary edema (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 2/26/27

Was there an autopsy? no

What test confirmed diagnosis? Clinical + Lab.

(Signed) Jno. A. Sharff, M. D.

, 19 (Address) Mrs John Hopper

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Druid Ridge. | March 8 1927 |
| 20 UNDERTAKER | ADDRESS |
| Chenowith & Son | 361 Chestnut St. |

Spec.—1-10-21—M&T—1500 Bks.

E 19817

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19817

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Maryland General Hospital

CITY OF BALTIMORE: (No. ..... ST. 14-20 WARD)

2-FULL NAME Mrs. Bertha Spook

(a) RESIDENCE NO. 1821 Bolton ST., WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Earl Sparks

6 DATE OF BIRTH (month, day, and year) Nov. 10th 1898

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs. or ....min. |
|---|---|---|---|---|
| | 28 | 3 | 27 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Queen Ann. Co Md

PARENTS

10 NAME OF FATHER Charles F. Duncan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Anna E Habbe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Deceased (Address)

15 Filed ..... 19 ..... C. HAMPSON JONES, M.D. Registrar

1927 G. H. SANDERLIN

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 7, 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 2, 1927, to Mar 7, 1927, that I last saw her alive on March 7, 1927, and that death occurred, on the date stated above, at 2.00 m.

The CAUSE OF DEATH* was as follows: Ruptured Ectopic Pregnancy

(duration) ..... yrs. ..... mos 5 ds.

CONTRIBUTORY (Secondary) Hemorrhage Surgical Shock

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? yes Date of 3-6-27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Church Hill, Md DATE OF BURIAL Mar 9 1927

20 UNDERTAKER W. W. Cook ADDRESS 502 E Monument

Spec.—6-9-19—H. P. Co.—1000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19818

## CERTIFICATE OF DEATH.

87 E 19818

12-50

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 334 Wheatridge Ave ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William John Anderson

(a) RESIDENCE. No. 334 Wheatridge ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | White | widower |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Amanda J Anderson

6 DATE OF BIRTH (month, day, and year) March 15. 1840

| 7 AGE Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|
| 86 | 11 | 22 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired sea Captain

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) Kent Delaware
(State or country)

PARENTS

10 NAME OF FATHER Wm Anderson

11 BIRTHPLACE OF FATHER (city or town) Scotland
(State or country)

12 MAIDEN NAME OF MOTHER Emaline Coyte

13 BIRTHPLACE OF MOTHER (city or town) Scotland
(State or country)

14 Informant Mrs J W Pflueger
(Address) 4608 Old Frederick Ave

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar
By ARB

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 22 . 1926 . to March 6 . 1927.
that I last saw him alive on March 6 . 1927.
and that death occurred, on the date stated above, at 11.25 P m.

The CAUSE OF DEATH* was as follows:

Chronic Pericarditus

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Paresis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas A Fetterhoff, M. D.

, 19 (Address) 1807 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| London Park Cem | Mar 9 1927 |

| 20 UNDERTAKER | ADDRESS |
|---|---|
| W M Cook | 502 E North Ave |

Spec.-7-17-26—A Co.—200 Bks.

Dr Ferry 9/10 W. Lombard

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E-19819

## CERTIFICATE OF DEATH

31 E-19819

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1412 Beet St. 24-33 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary D. Roche

(a) RESIDENCE NO. 1412 Beet St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Roche

6 DATE OF BIRTH (month, day, and year) March 12 - 86

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..hrs. or ..min.. |
|---|---|---|---|---|
| 40 11 24 | 41 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Thos. J. Conroy

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary Gutmuths

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Md

14 Informant George Roche

(Address) 1412 Beet St

15 Filed 1927 19 C. HAMPSON JONES M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6th 1927

17 I HEREBY CERTIFY, That I attended deceased from 5/3/26, 1926, to 3/6/, 1927, that I last saw h~~er~~ alive on 3/5/27, 19..., and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Chronic Nephritis.

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Pul. Tuberculosis - dx 1½ yr. no chaus

(duration) 2yr 5m yrs. mos. ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Bernard J. Ferry, M. D.

3/6/ 1927 (Address) 910 W. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — Date of Burial 3/10 1927

20 UNDERTAKER Uniman Cook — ADDRESS Sou. Howard

Spec.–7-17-26—A Co.—200 Bks.

E 19820

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

129 E 19820

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2705 N. Calvert St. 12-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosaline Hall Duncan

(a) RESIDENCE NO. 2705 N. Calvert St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred life mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John H. Duncan

6 DATE OF BIRTH (month, day, and year) November 8, 1867

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|---|
| | 59 | 3 | 29 30 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,

(State or country) Maryland

PARENTS

10 NAME OF FATHER George W. Hall

11 BIRTHPLACE OF FATHER (City or town) Newburn

(State or country) North Carolina

12 MAIDEN NAME OF MOTHER Jane Norwood

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant Mildred V. Duncan

(Address) 2705 N. Calvert St.

15 Filed C. HAMPSON JONES, M. D. Registrar

1927 Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Mar. 1, 1927, to Mar. 7, 1927, that I last saw her alive on Mar. 6, 1927 and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis. (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Mortimer C. Blake, M. D.

3-7 1927 (Address) 1014 W. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — Date of Burial Mar. 9 27

20 UNDERTAKER Joseph D. Cook — ADDRESS 1003 W. Balto St.

Very Important: Be sure that every question is answered.

Spec. 1-10-21 M&T 1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

**19821** CERTIFICATE OF DEATH ~~31~~ E **19821**

1-PLACE OF DEATH Balto City Hospitals REGISTERED NO. 21-69

CITY OF BALTIMORE: (No. Balto. Md. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Bock

(a) RESIDENCE NO. 421 S. Smallwood St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 9 1907

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| 20 | 19 | 2 | 26 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brush Maker

(b) General nature of industry, business, or establishment in which employed (or employer) Factory

(c) Name of employer Calvert Metal Co.

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Adam Bock

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria Hungary

12 MAIDEN NAME OF MOTHER Anna Emerich

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria Hungary

14 Informant Balto City Hospts

(Address) Balto Md

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-7 1927

17 I HEREBY CERTIFY, That I attended deceased from 11-20-, 1924, to 3-7, 1927, that I last saw h[im] alive on 3-6-, 1927 and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tbc.

Tuberculous Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Dementia Praecox, Catatonic Reaction type

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical findings

(Signed) Harry Fredonnet, M.D.

3/7/27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: Mar. 10 27

20 UNDERTAKER: Capt P Cook — ADDRESS: 1003 W. Balto St

Spec.–7-17-26–A Co.—200 Bks.

Passagno 2314 E Balto

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 19822

REGISTERED NO. 129 E 19822

1-PLACE OF DEATH

City of BALTIMORE: (No. 224 Stemmers St. Ward 5)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Gorrell

(a) RESIDENCE NO. 224 Stemmers St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Jennie Gorrell

6 DATE OF BIRTH (month, day, and year) Jan. 31 - 1868

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 59 | 1 | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer on Dock

(b) General nature of industry, business, or establishment in which employed (or employer) Wagons

(c) Name of employer Starkey Co

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Jennie Gorrell

(Address) 224 Stemmers Alley

15 Filed MAR 2 - 1927 19 H. HAMPSON JONES M. D. Registrar

Per RJC

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 19 27

17 I HEREBY CERTIFY, That I attended deceased from March 1, 19 27 to March 6, 19 27

that I last saw h~~e~~ alive on March 5, 19 27

and that death occurred, on the data stated above, at 5:00 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis 2

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Data of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. L. Pessagno M. D.

3. 7. 1927 (Address) 514 Drury Lane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetary

Date of Burial 3/8 19 27

20 UNDERTAKER William Cook

ADDRESS 502 E Nor

Spec.—1-10-21—M&T—1500 Bks.

Bertie Woods

# HEALTH DEPARTMENT—CITY OF BALTIMORE

19823

## CERTIFICATE OF DEATH.

31 E 19823

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1117 McCulloh ST. 11-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ~~Mr~~ Bertie Woods

(a) RESIDENCE NO. 1117 McCulloh ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem.

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): married

6a If married, widowed, or divorced ~~HUSBAND of~~ or) WIFE of: Jas. Woods

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 33 | Months — | Days — | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Jos. Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Hamit Nelson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Amandie Bopir (Address) 1414 Mosher ave

15 Filed MAR 8 - 1927 C. HAMPSON JONES, M.D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar. 6 1927

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1926 to mar 6, 1927.

that I last saw h~~e~~r alive on mar 6, 1927

and that death occurred, on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ... yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Hans E. Hagmot M. D.

3/7, 1927 (Address) 1006 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: mill creek-middle Pass

DATE OF BURIAL: march 8 1927

UNDERTAKER: Edward Bryan

ADDRESS 1691 orleans st

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19824

## CERTIFICATE OF DEATH.

E 19824

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital (ST.) 25-72 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis A Knecht

(a) RESIDENCE NO. Hallethorpe PO. (ST.) Knecht Ave (WARD) 24

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): wife married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna Knecht

6 DATE OF BIRTH (month, day, and year): July 6 1889

7 AGE: Years 37 | Months 8 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: John Louis Knecht

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Mary A. Kaiser

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant: Mrs Anna Knecht

(Address): Hallethorpe PO. Md

15 Filed 1927, 19 C. HAMPTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3-6 1927

17 I HEREBY CERTIFY, That I attended deceased from 3-5, 1927, to 3-6, 1927, that I last saw him alive on 3-6, 1927, and that death occurred, on the date stated above, at 2.30 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac & Renal insufficiency

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Tests

(Signed) J. Theron Hunter, M. D.

3/6. 1927 (Address) St. Agnes' Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: March 9 1927

20 UNDERTAKER: Henry Hordt & Son — ADDRESS: 1301 E Eager St

Spec.—12-9-25—A Co.—200 Blks.

E 19825

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129 E 19825

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St. 15-21 Ward)

2-FULL NAME Edward A. Brigham

(a) RESIDENCE NO. 2002 N. Monroe St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widower |

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Kate Brigham

6 DATE OF BIRTH (month, day, and year) about 1858

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| About | 69 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plaster

(b) General nature of industry, business, or establishment in which employed (or employer) [illegible]

(c) Name of employer

9 BIRTHPLACE (city or town) Boston

(State or country) Mass

PARENTS

10 NAME OF FATHER Benjamin Brigham

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Mass

12 MAIDEN NAME OF MOTHER Margaret

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Mass

14 Informant _____

(Address) Records

15 Filed 3-26-1927 C. HAMPTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 1927

17 I HEREBY CERTIFY, That I attended deceased from March 5, 1927, to March 6, 1927, that I last saw him alive on March 6, 1927, and that death occurred, on the date stated above, at 3:20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Hypertension

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of _____

Was there an autopsy? Yes

What test confirmed diagnosis? Gross & Laboratory

(Signed) R. Hoopes Smith, M. D.

March 29 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery Date of Burial March 8 1927

20 UNDERTAKER Wm J. Jackson & Son ADDRESS Norfolk, Va.

Spec.—7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

19826 90 E 19826

## CERTIFICATE OF DEATH

REGISTERED NO. 8-45

1-PLACE OF DEATH

City of BALTIMORE: (No.) 2205 Mayfield Ave. (St.) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward P. McIntyre

(a) RESIDENCE NO. 2205 Mayfield Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. 5 mos. 19 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Helen E. McIntyre

6 DATE OF BIRTH (month, day, and year) Sept 15, 1865

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min.. |
|---|---|---|---|---|
| | 61 | 5 | 19 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ship Builder

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self Balto.

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER Edw. P. McIntyre

11 BIRTHPLACE OF FATHER (City or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Patrick

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Mrs. Helen E. McIntyre

(Address) 2205 Mayfield Ave.

C. HAMPTON JONES, M. D.

Filed MAR 1927 Per Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 6 19 27

17 I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19....

that I last saw h... alive on ....., 19....

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic

(duration) yrs. mos. ds.

CONTRIBUTORY Hypertension

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) ....., M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Pk Cemetery — Date of Burial Mar 9 1927

20 UNDERTAKER Wm Flickinger Sons — ADDRESS Morelle

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

114 E 19827

## CERTIFICATE OF DEATH.

E 19827

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1435 Barclay St. 12-50 (WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ida Wood

(a) RESIDENCE NO. 1435 Barclay ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles H. Wood

6 DATE OF BIRTH (month, day, and year): June 24-1856

7 AGE — Years: 70 | Months: 8 | Days: 9 | If LESS than 1 day, hrs. or min.: 11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Carroll Co Md

PARENTS

10 NAME OF FATHER: Peter Engel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Carroll Co

12 MAIDEN NAME OF MOTHER: Mary Cassell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Carroll Co

14 Informant (Address): Walter H. Wood 1435 Barclay St

15 Filed MAR 8 1927 19 C. HARRISON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 5 1927

17 I HEREBY CERTIFY, that I attended deceased from Nov 22 1926 to March 5 1927.

that I last saw h[illegible]ive on March 5 1927

and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis —

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W S Gunn — M. D.

3/6/27 (Address) 6722 Wis Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemetery | DATE OF BURIAL: Mar 8 1927

UNDERTAKER: D B Marshall | ADDRESS: 3539 Edmondson Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

19828

## CERTIFICATE OF DEATH.

61-002

E 19828

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hosp. St., 25-74 Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. John Thomas Crone Jr.

(a) Residence No. English Consul, Md. Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. 2 How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

4-SEX. Male

5-COLOR OR RACE. White

6-Single, Married, Widowed, or Divorced (Write the word.) Infant.

7a-If married, widowed, or divorced HUSBAND of (or) WIFE of

7-DATE OF BIRTH (month, day and year) Mar. 3 '27

8-AGE. yrs. mos. 2 ds. If LESS than 1 day, hrs. or min.?

9-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Infant
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Baltimore Maryland

PARENTS.

10-NAME OF FATHER. William Crone

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Maryland

12-MAIDEN NAME OF MOTHER. Anna Zibe

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore Maryland

14- (Informant) William Crone
(Address) English Consul, Md.

15- Filed MAR 8 - 1927 C. HAMILTON JONES, M. D. Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 5 1927.

17- I HEREBY CERTIFY, That I attended deceased from March 3 1927 to March 5 1927 that I last saw h[illegible] alive on March 5 1927 and that death occurred, on the date stated above, at 1:15 P. M.

The CAUSE OF DEATH* was as follows:
Congenital Atelectasis.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Prolonged labor followed by instrumental delivery

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) Margaret B. Ballard M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. University Hosp DATE OF BURIAL. , 19

20-UNDERTAKER. ADDRESS

c.—1-12-23—M&T—500 Blks.

200761

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19829

## CERTIFICATE OF DEATH

E 19829

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSP ST. 16-23 100-30 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alphonse Parker

(a) RESIDENCE No. 813 N Calhoun ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX: male

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced, (write the word): single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of —

DATE OF BIRTH (month, day, and year) Aug 22, 1926

| AGE | Years | Months | Days | If LESS than 1 day, hrs or min |
|---|---|---|---|---|
| | | 6 | 14 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) — —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Odell Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Verna ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records

(Address)

15 Filed JOHNS HOPKINS HOSP 1927 C. HAMPSON JONES, Registrar

R Opie, M. D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 6 1927.

17 I HEREBY CERTIFY, That I attended deceased from Mar. 2, 1927, to Mar. 6, 1927,

that I last saw h alive on Mar 6, 1927

and that death occurred, on the date stated above, at 400 A m.

The CAUSE OF DEATH* was as follows:

Acute Primary Pneumonia

Broncho-pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 813 N Calhoun

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. E. Handley, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Ziona

DATE OF BURIAL March 8 1927

20 UNDERTAKER Leonard Wheeler

ADDRESS 107 Myrtle Ave

ec.—6-9-19—H. P. Co.—1000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19830

E 19830

## CERTIFICATE OF DEATH.

X 31

1-PLACE OF DEATH

ITY OF BALTIMORE: (No.) 302 Cleveland ave (or Helena) (WARD) 26-36

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Martin Petrak

(a) RESIDENCE. NO. 302 Cleveland ave ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. 10 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth Gross

6 DATE OF BIRTH (month, day, and year): Dec 26. 1881

7 AGE: Years 45 Months 2 Days 9 11 If LESS than 1 day, ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Steel Mill Worker

(b) General nature of industry, business, or establishment in which employed (or employer): C&O

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Carleton Mich

PARENTS

10 NAME OF FATHER: John Petrak

11 BIRTHPLACE OF FATHER (city or town) (State or country): Michigan

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Elizabeth Petrak

(Address): 302 Cleveland ave (St Helena)

15 Filed: APR 8 - 1927 [illegible] Registrar.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 17, 1927, to March 7, 1927, that I last saw him alive on March 6, 1927, and that death occurred, on the date stated above, at 8-30 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis (Miliary)

(duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary): None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) A. W. Reier, M. D.

3/7. 1927 (Address) Dundalk, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem

DATE OF BURIAL: Mar 10 1927

20 UNDERTAKER: John Ullrich

ADDRESS: 2008 Eastern

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 19831 ✓ 117 E 19831

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospital St., 76-37 Ward)

2-FULL NAME Daniel Jones -

(a) RESIDENCE NO. 824 S 14th St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| M | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose A Jones

6 DATE OF BIRTH (month, day, and year) Feb 12 1897

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 30 | — | 19 23 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER John W Jones

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Betts

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Balto City Hosp (Address) Record

15 Filed ..... 19 ..... C. HARRISON JONES, M. D. Registrar

MAR - 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5. 1927 19

17 I HEREBY CERTIFY, That I attended deceased from 2-25- 1927, to 3-5- 1927, that I last saw h.. alive on 3-5- 1927, and that death occurred, on the date stated above, at 3 45 m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

Generalized Peritonitis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Septicemia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of Feb. 25. 1927

Was there an autopsy? No

What test confirmed diagnosis? Laboratory & Clinical

(Signed) Bayless, M. D.

19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery Date of Burial MAR 9 1927

20 UNDERTAKER John F Denny ADDRESS 715 L St.

ec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19832

## CERTIFICATE OF DEATH.

3 E 19832

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 815 N. Wallas ST., 7-13 WARD)

2-FULL NAME Alexander Newton

(a) RESIDENCE NO. 815 N. Wallas ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4y yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | C | Married |

6 If married, widowed, or divorced HUSBAND of (or) WIFE of ?

DATE OF BIRTH (month, day, and year) — — 1891

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| 36 | 35 | ? | ? | |

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffer

(b) General nature of industry, business, or establishment in which employed (or employer) 023

(c) Name of employer Hoffberger Tea Co.

8 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Howard Newton

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country) Md.

12 MAIDEN NAME OF MOTHER Lottie Hill

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md.

14 Informant mother

(Address)

Filed MAR 8 - 1927 HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3 · 4 1927

17 I HEREBY CERTIFY, That I attended deceased from 2 · 27, 1927, to 3 · 4, 1927, that I last saw h alive on 3 · 4, 1927, and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Acute myocarditis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin. Obs.

(Signed) W. C. Berry, M. D.

, 19 (Address) 1500 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Astury Cemtry

DATE OF BURIAL Mar 8 1927

20 UNDERTAKER Robert E. Williams

ADDRESS 1515 McCulloh St

Spec.—12-9-25—A Co.—200 Bks.

E 19833

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 19833

## CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1504 Boyle St., 24-34 Ward)

2-FULL NAME Joseph A. White

(a) RESIDENCE NO. 1504 Boyle St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Aug 17/24

| 7 AGE | Years | Months | Days | IF LESS than 1 day ...hrs. or ...min. |
|---|---|---|---|---|
| | | 6 | 19 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country): Md.

PARENTS

10 NAME OF FATHER: Carroll White

11 BIRTHPLACE OF FATHER (city or town): Balto

(State or country)

12 MAIDEN NAME OF MOTHER: Mary Anderson

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country)

14 Informant: Mrs White

(Address): 1504 Boyle St

15 Filed ... 19 ... HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 1, 1927, to Mar 6, 1927, that I last saw h... alive on Mar 6, 1927, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary): Influenza

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm. A. Campbell, M. D.

March 7, 1927 (Address) 7644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem — Date of Burial: March 9 1927

20 UNDERTAKER: Chas. L. Stevens — ADDRESS: 1501 E Fort Ave

MAR 8 1927

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19834

## CERTIFICATE OF DEATH.

24-35 31

E 19834

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1617 Cuba St. ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry F. Beal.

(a) RESIDENCE NO. 1617 Cuba St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs. 4 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 Color or Race: White.

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If ~~MARRIED~~, widowed, or ~~DIVORCED~~ HUSBAND of ~~OR WIFE OF~~: Elizabeth Beal.

6 DATE OF BIRTH (month, day, and year): October 23, 1874

7 AGE: Years 52 Months 4 Days 13 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Thomas F. Beal.

11 BIRTHPLACE OF FATHER (city or town):

(State or country): St. Marys Co. Md.

12 MAIDEN NAME OF MOTHER: Josephine McCoy.

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): St. Marys Co. Md.

14 Informant: Mary Fenzel. (sister)

(Address): 1617 Cuba St.

Filed MAR 8 1927 19..... C. HAMPSON JONES, M. D.

Per ..... Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 5, 1927 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

(duration) .....yrs. .....mos. .....ds.

(Signed) Otto M. Leonhardt M. D.
(Coroner)

3/7, 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ..... mos., ..... ds. In the State ..... yrs., ..... mos., ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross, Y.P.Co. Date of Burial: March 9 1927

20 UNDERTAKER: Wm. A. Stevens ADDRESS 1501 E. Fort Ave

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

19835

## CERTIFICATE OF DEATH.

179 E 19835

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St. 1-3 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Winkelman

(a) RESIDENCE NO. 2531 Fleet St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widowed |

3a If married, widowed, or divorced HUSBAND of (or) WIFE of George Winkelman

6 DATE OF BIRTH (month, day, and year) Nov 6. 1870

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 56 | 4 | 0 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Andrew Ayres

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Not Known

14 Informant Harry C. Winkelman

(Address) 320 S. Duncan St

15 Filed - 1927 G. HAMPSON JONES, M. D. Registrar

Per

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 6 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acc. Burns 3rd & 4th degree.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 1 ds.

Mar 7 27 (Signed) G. E. Yates M. D.

(Coroner)

(Address) 143 E. Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Baltimore Cem. | Mar 8 1927 |
| **20 UNDERTAKER** | **ADDRESS** |
| Henry Harder & Son Inc. | 1710 Fleet St. |

Burns

Spec.–7-17-26—A Co.—200 Bks.

E 19836

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

## CERTIFICATE OF DEATH

E 19836

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Beechfield Ave 26-11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hannah Brown

(a) RESIDENCE NO. Beechfield Ave Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Isaac Brown

6 DATE OF BIRTH (month, day, and year): 1862

7 AGE: Years 65 Months Days IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Calvert Co. (State or country) Md

PARENTS

10 NAME OF FATHER Cirbrace Evans

11 BIRTHPLACE OF FATHER (City or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant: Isaac Brown (Address) 1615 N. Fremont Ave

15 Filed MAR 6 1927 G. HAMILTON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): March 4-1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1926, to March 4, 1927, that I last saw h alive on March 4, 1927, and that death occurred, on the date stated above, at 4 p.m.

The CAUSE OF DEATH* was as follows:

Acute Broncho Pneumonia

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) W. A. Buell, M. D.

3/6, 1927 (Address) Irvington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem Date of Burial 3/8 27

20 UNDERTAKER: Edward Handley ADDRESS 7 N Bond St

Spec.–7-17-26—A Co.—200 Bks.

E 19837

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

11-001

E 19837

REGISTERED NO. _____

1-PLACE OF DEATH

City of BALTIMORE: (No. 1552 Woodyear St. 15-21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lila Perry

(a) RESIDENCE NO. 1552 Woodyear St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug. 24- 1908

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|---|
| | 18 | 6 | 12 | 10 |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER: Aaron Perry

11 BIRTHPLACE OF FATHER (City or town): Md

(State or country)

12 MAIDEN NAME OF MOTHER: Mary Oliver

13 BIRTHPLACE OF MOTHER (city or town): Md

(State or country)

14 Informant: Mary Perry

(Address)

Filed ..... 19 ..... C. HAMPSON JONES, M. D. ..... Registrar

MAR 8 - 1927 Per RR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1927, to Mar 4, 1927, that I last saw her alive on Mar 4, 1927, and that death occurred, on the date stated above, at 1 05 A m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Weakness + Bronchitis

Focal TB Chest test (duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Thos J Woodcock Jr, M. D.

3-8, 1927 (Address) 1630 Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hilson

Date of Burial 3/8 1927

30 UNDERTAKER: Sumwalt & Quesley

ADDRESS 1528 Eutaw

pec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

19838

## CERTIFICATE OF DEATH.

74-001

REGISTERED No. 19838

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 4402 Greenway ST. Unknown WARD)

2-FULL NAME Annie Hooker

(a) RESIDENCE NO. 527 Robert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Tom Hooker ?

6 DATE OF BIRTH (month, day, and year)

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 86 | - | - | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md - U.S.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs W Litridge (Address) 4402 Greenway - Guilford

15 Filed 3/8 1927 THAMPSON JONES, M. D. Registrar

Per R.M.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 5 1927

17

I HEREBY CERTIFY, That I attended deceased from March 3, 1927, to March 5, 1927, that I last saw h[illegible] alive on March 5, 1927 and that death occurred, on the date stated above, at 2:10 p. m

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs mos ds

CONTRIBUTORY (Secondary) old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw. J. Wheatley, M. D

3/8, 1927 (Address) 1228 Smith Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Zion Cem.

DATE OF BURIAL: 3/8/27

20 UNDERTAKER: Mrs. Geo. H. Holland

ADDRESS: 1618 Edmondson Ave

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

19839

## CERTIFICATE OF DEATH.

REGISTERED NO. 19839

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Aged Women Home St. 19-27 Ward)

2-FULL NAME Laura J. Ramm

(a) RESIDENCE NO. 1400 W Lexington St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Wid

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 25, 1856.

| 7 AGE Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|
| 70 | 11 | 7 | 12 |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None - ppl

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): York

(State or country): Pa

PARENTS

10 NAME OF FATHER: Charles E Henry

11 BIRTHPLACE OF FATHER (city or town):

(State or country): York Pa

12 MAIDEN NAME OF MOTHER: Barbara Hough

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): York Pa

14 Informant: Ella J Jones

(Address) 1400 W Lexington

Filed ..... 19..... HAMPSON JONES, M. D.
Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 7 1927 5:30 A.M.

17 I HEREBY CERTIFY, That I attended deceased from Feb 12 19 27 to March 7, 19 27,

that I last saw h..... alive on March 6, 19 27,

and that death occurred, on the date stated above, at 5:30 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. 24 ds.

CONTRIBUTORY (Secondary): Pulm. Oedema

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date No

Was there an autopsy?

What test confirmed diagnosis? J J Norwood

(Signed) ..... M. D.

March 7 19 27 (Address) 1363 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Loudon Park Date of Burial Mar 8 1927

20 UNDERTAKER: George J Smith ADDRESS Hollins 153 L

MAR 8 - 1927

Pa

Spec.—1-10-21—M&T—1500 Blks.

E 19840 HEALTH DEPARTMENT—CITY OF BALTIMORE E 19840

CERTIFICATE OF DEATH.

401-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 19 Ailsa ave Hamilton 27-44 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.

2-FULL NAME Virginia B. Jones

(a) RESIDENCE NO. 19 Ailsa Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry L. Jones

6 DATE OF BIRTH (month, day, and year): Dec 17. 1857

7 AGE: Years 69 Months 2 Days 16 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: home duties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore and

PARENTS

10 NAME OF FATHER: George C. Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Zink

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Mrs Frances Bodine 1020 N. Bond St

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per K.H.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 5 1927

17

I HEREBY CERTIFY, That I attended deceased from March 2nd, 1927, to March 5, 1927, that I last saw h.. alive on March 5, 1927, and that death occurred, on the date stated above, at 4.15 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Dr Chas Degen, M. D.

, 19 (Address) 1702 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Friends Cemetery

DATE OF BURIAL: March 8 1927

20 UNDERTAKER: John Waidelich

ADDRESS: 1900 Eutaw Place

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

101-001

E 19841

E 19841 REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 128 N. Kenwood Ave St. 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Capt. Marshall K. Crowell.

(a) RESIDENCE NO. 128 N. Kenwood ave St. 6 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nora Crowell.

6 DATE OF BIRTH (month, day, and year) May 14th 1854

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|---|
| | 72 | 9 | 21 23 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Sea Captain

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer Born at sea off the Coast of Bengal India

9 BIRTHPLACE (city or town) on an American vessel.

(State or country)

PARENTS

10 NAME OF FATHER Benajah Crowell

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Mass.

12 MAIDEN NAME OF MOTHER Almira Hardy

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Mass.

14 Informant Nora Crowell (Wife)

(Address) 128 N. Kenwood Ave

15 Filed MAR 10 1927 C. HAMPTON JONES, M. D. Registrar

Per L P

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 1927

17 I HEREBY CERTIFY, That I attended deceased from March 4, 1927, to March 7, 1927, that I last saw alive on March 7, 1927, and that death occurred, on the date stated above, at 11.45 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Valvular Disease Heart

(duration) 2 yrs. mos. ds.

18 Where was disease contracted

If not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) C. Green, M. D.

3/8/27 (Address) 406 Bath St Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — Date of Burial March 10th 1927

20 UNDERTAKER Lilly & Zeiler — ADDRESS 1033 Mass Ave

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 19842

## CERTIFICATE OF DEATH

E 19842

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 103 S. Bouldin St., 26-11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Russell Calvin Schneff.

(a) RESIDENCE NO. 103 S. Bouldin St. 26 Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 6 mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single. |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 28 1926

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|---|
| | | 6 | 8 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER Charles J. Schneff

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary Bess Wilson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto. Md.

14 Informant Chas. J. Schneff.

(Address) 103 S. Bouldin St

15 Filed Apr 8 - 1927 C. HAMPSON JONES M. D. Registrar

By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 6th 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 26, 1927, to March 5, 1927, that I last saw him alive on March 5, 1927, and that death occurred, on the date stated above, at 4 AM m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. A. Mayer, M. D.

(Address) 2012 E Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivett Cemetery — Date of Burial Mch 8 1927

20 UNDERTAKER Lillye Zeiler — ADDRESS 1138 N. Wolfe

Spec.–7-17-26 — Co. 300 Blks

# E 19843 HEALTH DEPARTMENT—CITY OF BALTIMORE

11-001 E 19843

## CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3003 Tait ave St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Dorothea Bentz

(a) RESIDENCE NO. 3003 Tait Ave St. 1 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 13 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 17th 1926

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min.. |
|---|---|---|---|---|
| ~~13~~ | 1 | 1 ~~mo~~ | 19 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant ~~no~~

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER Edward Bentz

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Margaret Davis

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto. Md.

14 Informant Edward Bentz

(Address) 3003 Tait Ave.

15 Filed ~~Nov~~ 1927, 19 — R. HARRISON JONES, M. D., Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6th 1927

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1927, to March 6, 1927,

that I last saw h~~er~~ alive on March 6, 1927,

and that death occurred, on the date stated above, at 5:30 a. m.

The CAUSE OF DEATH* was as follows:

Grippe

(duration) yrs. ~~0~~ mos. 7 ds.

CONTRIBUTORY (Secondary) Bronch-Pneumonia

(duration) yrs. ca mos. 5 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M. Jamison M. D.

3/7. 1927 (Address)

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Pauls Cemetery

Date of Burial March 8th 1927

20 UNDERTAKER Zilly-Zilly

ADDRESS 4035 Wash Ave

...es. 6-2-19—H. P. Co.—1000 Bks.

# E 19844 HEALTH DEPARTMENT—CITY OF BALTIMORE E 19844

## CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 10 N. Montford Ave (610) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Anna R. Reisinger

(a) RESIDENCE. No. 10 N. Montford Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| F. | W. | Single |

a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) June 4-1893

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 33 | 9 | 1 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer): 069

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Balto. Md.

10 NAME OF FATHER: John Reisinger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Austria

12 MAIDEN NAME OF MOTHER: Barbara Schwarz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

Informant (Address): John Reisinger 10 N. Montford Ave

Filed ... 19 ... Registrar. C. HAMPSON JONES, M. D.

R8 - 152 Per RLC

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 23, 1927, to March 5, 1927

that I last saw her alive on March 5, 1927

and that death occurred, on the date stated above, at 11 ; P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary) X X

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys. Exam. X-ray. Sputum

(Signed) Carlos I. Suggett, M. D.

, 19 (Address) Tuberculosis Dispy 111 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Loy Redeemer Cem't | March 9 1927 |
| 20 UNDERTAKER | ADDRESS |
| Lilly Zieber | 403 S. Wolfe |

Spec—12-23-21—E.B.R.S.—400 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

19845

## CERTIFICATE OF DEATH.

E 19845

1-PLACE OF DEATH 840. W. 33.rd.Street. Registered No.....

City of BALTIMORE: (No. 840. W. 33.rd. Street. St. ..... Ward) 13-52 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Eliza C. Jeffries.

(a) Residence No. 840. W. 33.rd.Street. St., ..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female.

4-COLOR OR RACE. White.

5-Single, Married, Widowed, or Divorced, (write the word.) Widow

5a-If married, widowed, or divorced, WIFE of Wm. S. Jeffries.

6-DATE OF BIRTH (month, day and year) Aug. 13/1846.

7-AGE. 80 yrs. 6 mos. 24 ds. If LESS than 1 day, ....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... house work

(b) General nature of industry, business, or establishment in which employed (or employer)..... at home.

(c) Name of employer..... Retired.

9-BIRTHPLACE (city or town)..... Baltimore Co.
(State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, William Lee.

11-BIRTHPLACE OF FATHER (city or town)..... Balto. Co.
(State or Country), Maryland.

12-MAIDEN NAME OF MOTHER, Unknown.

13-BIRTHPLACE OF MOTHER (city or town)..... Unknown.
(State or Country),

14- (Informant)..... Mrs, Cora Allison. (daughter)

(Address)..... 840. W. 33.rd. Street.

3 - 1927 Filed ..... 192 ..... C. HARRY JONES, M. D. Registrar.

Per RLC

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March. 7. th/27

17- I HEREBY CERTIFY, That I attended deceased from Jan 24 1927 to Mar 7 1927

that I last saw h..er alive on Mar 7 1927

and that death occurred, on the date stated above, at 9-50. Am.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

3/8/27 (Signed) Kiron Brailford M. D.

(Address) # 840. W. 33.th. St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

| 19-PLACE OF BURIAL, CREMATION OR REMOVAL. | DATE OF BURIAL. |
|---|---|
| Jessups, Balto. Co. Md. | March, 9, 1927. |
| 20-UNDERTAKER. | ADDRESS |
| J. Walter Davis. | # 3307 Paine. St. |

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19846

## CERTIFICATE OF DEATH.

85 E 19846

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) West Balto. Gen. St., (Hospital) Ward) 12-51

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Carter

(a) RESIDENCE NO. 507 W. 28th St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widow

6 DATE OF BIRTH (month, day, and year): not Known

7 AGE — Years: 84 — Months: — Days: — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Lady

(b) General nature of industry, business, or establishment in which employed (or employer): Retired Life

(c) Name of employer: None

9 BIRTHPLACE (city or town): Baynesville Balto Co

(State or country): Md

PARENTS

10 NAME OF FATHER: Wm. Bayne

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Maryland

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Not Known

14 Informant: Maurice Carter

(Address): 507 W. 28th St

Filed MAR 8 1927

C. HAMPSON JONES, M. D.

Per [illegible] Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 6. 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Tibia (Left) Fell down Stairs in own home (accidental) (duration) .....yrs. .....mos. 3 ds.

CONTRIBUTORY (Secondary) acute uremia (duration) .....yrs. .....mos. 2 ds.

(Signed) J. T. Hennessy, M. D. (Coroner)

March 6, 1927 (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem Date of Burial: Mar. 9 1927

20 UNDERTAKER: John Burns Sons ADDRESS: Town

Spec.—12 9 25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19847

101-001

## CERTIFICATE OF DEATH.

REGISTERED NO. E 19847

1-PLACE OF DEATH

City of BALTIMORE: (No. 2026 Fountain St. 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances A. Dulowski

(a) RESIDENCE NO. 2026 Fountain St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? 15 yrs. _____ mos. _____ ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Stanislaus Dulowski

6 DATE OF BIRTH (month, day, and year): unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 52 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Poland

(State or country)

PARENTS

10 NAME OF FATHER: Martin Krupka

11 BIRTHPLACE OF FATHER (city or town): Poland

(State or country)

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Poland

14 Informant: Stanislaus Dulowski.

(Address) 2026 Fountain St.

15 Filed 1927 G. HAMDEN JONES, M. D. Registrar

By RM

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: March 6 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan. 30, 1927, to March 5, 1927, that I last saw h[illegible] alive on March 5, 1927, and that death occurred, on the date stated above, at 1.50 P. m.

The CAUSE OF DEATH* was as follows:

Acute Carditis

(duration) .....yrs. .....mos. 20 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No S. D.

What test confirmed diagnosis? .....

(Signed) John J. Krage, M. D.

, 19 (Address) R F Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy-Rosary. Date of Burial: Mar. 9 1927.

20 UNDERTAKER: M. J. Sadowski. ADDRESS: 705 S. Ann St.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19848

## CERTIFICATE OF DEATH.

46 E 19848

1-PLACE OF DEATH Maryland Gen Hosp

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ✓ ST., 6-10 WARD)

2-FULL NAME Mrs. Olive White

(a) RESIDENCE NO. 128 N. Milton Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles White

DATE OF BIRTH (month, day, and year) April 16, 1870.

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 56 | 10 | 19 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Robert Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Eliz Armistead

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Charles H. White

(Address) 128 N. Milton ave.

Filed 19

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 1927.

17 I HEREBY CERTIFY, That I attended deceased from Feb 28, 1927, to March 7, 1927,

that I last saw h[illegible] alive on March 7, 1927,

and that death occurred, on the date stated above, at 7 35A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus and bladder

(duration) ? yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Septic Peritonitis

& Pul Edema (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes Date of March 2, 1927.

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Jay Abrahamson M. D.

(Address) 9/12/27 [illegible] Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mathews Co. Va. DATE OF BURIAL March 8 1927

20 UNDERTAKER Wm E. Black ADDRESS 922 N. Broadway

[illegible] HAMILTON JONES, M. D.

ec.—1-12-23—M&T—500 Bks.

E 19849

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19849

## CERTIFICATE OF DEATH.

REGISTERED NO. 9

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. JOHNS HOPKINS HOSP ST. 22-31 WARD)

2-FULL NAME Howard Wilson

(a) RESIDENCE NO. 235 Hill St. ST. City WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

6 If married, widowed, or divorced HUSBAND of (or) WIFE of —

DATE OF BIRTH (month, day, and year) Aug 30th 1926

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | | 7 mos. | 7 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md -

PARENTS

10 NAME OF FATHER Ernest Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md -

12 MAIDEN NAME OF MOTHER Edith Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md -

14 Informant Records -

(Address) JOHNS HOPKINS HOSP

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per RRB

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 7, 1927, to March 7, 1927, that I last saw him alive on March 7, 1927 and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Rickets, Pertussis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Pneumonia, Bronchs.

(duration) yrs mos. 20 ds.

18 Where was disease contracted if not at place of death? 235 S. Hill St.

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? autopsy

(Signed) H. E. Hamdlug, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet

DATE OF BURIAL March 9 1927

20 UNDERTAKER E. Schloman & Son

ADDRESS 1037 Hanover St

Spec.—1-10-21—M&T—1500 Bks.

E 19850

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19850

101-607

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 830 Hollins St. 18-29 WARD)

2-FULL NAME Vladislova Ambrazas

(a) RESIDENCE NO. 830 Hollins St., ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. ds. How long in U. S., if of foreign birth? 26 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widowe

6 DATE OF BIRTH (month, day, and year): No. 1871

7 AGE: 56 Years — Months — Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: No. gd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Liethvania

PARENTS

10 NAME OF FATHER: Peter Baltatis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Liethvania

12 MAIDEN NAME OF MOTHER: M. Olcesuki

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Liethvania

14 Informant (Address): A. Mandravickas 830 Hollinns St.

15 — 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar. 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 26, 1927, to Mar. 7, 1927.

that I last saw her alive on Mar. 6, 1927.

and that death occurred, on the date stated above, at 9.30 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) — yrs. — mos. 2 — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) John A. Kondmer, M. D.

, 19 (Address) 375 Strickland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: March 9, 1927

20 UNDERTAKER: John Grebliauckas — ADDRESS: 423 S. Paca St

Spec.—12-9-25—A Co.—200 Bks.

Calcagno

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19851

## CERTIFICATE OF DEATH.

90 E 19851

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 205 North Curley Street St. 6-11 Ward)

2-FULL NAME Laura Calcagno

(a) RESIDENCE NO. 205 Curley Street St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Salvitore Calcagno

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years: About 62 | Months: — | Days: | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country) Italy

PARENTS

10 NAME OF FATHER Joseph Lopinto

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Italy

12 MAIDEN NAME OF MOTHER Frances ?

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Italy

14 Informant: Joseph Calcagno

(Address) 404 [illegible]

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per [illegible]

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

March 8/1927

17 I HEREBY CERTIFY, That I attended deceased from Febr. 25 19 27, to March 8, 19 27, that I last saw h[illegible] alive on March 8, 19 27, and that death occurred, on the date stated above, at 2.45 A.M.

The CAUSE OF DEATH* was as follows:

Cancer Abdomen

Thrombosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Clinical

What test confirmed diagnosis?

(Signed) P. Antigone, M. D.

, 19 (Address) 2944 Virginia

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — Date of Burial: 3/10 1927

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E Monument

Spec.—7-17-26—A Co.—200 Bks.

Dr Box 1123 N. Charles ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19852

185

E 19852

# CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 317 Simpson St St. 28-6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clemency Lee Noyes

(a) RESIDENCE NO. 317 Simpson St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Miller S Noyes Sr.

6 DATE OF BIRTH (month, day, and year) Dec 3/1866

| 7 AGE | Years | Months | Days |
|---|---|---|---|
| | 60 | 7 | 8 |

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housepainter (37)

(b) General nature of industry, business, or establishment in which employed (or employer) Roofing

(c) Name of employer Self. Balto Co.

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER John Noyes.

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Emma Edith

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto Co

14 Informant Louis Noyes.

(Address) 1512 Dukeland St

15 Filed ... 1927 C. HAMPSON JONES, M. D., Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7/1927. 19

17 I HEREBY CERTIFY, That I attended deceased from July, 19 26, to Mch 7, 19 27,

that I last saw h.. alive on Mch 7, 19 27,

and that death occurred, on the data stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Senile Dementia

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Fracture Hip

Accidental Fall

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? 317 Simpson St.

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

. 19 (Address) 3506 Park Heights Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Restertown M E Cem

Date of Burial 3/9 19 27

20 UNDERTAKER M Cook

ADDRESS 501 N Mt

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19853

## CERTIFICATE OF DEATH

90 E 19853

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1411 Battery ave. 2433 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Burns.

(a) RESIDENCE NO. 1411 Battery ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Burns.

6 DATE OF BIRTH (month, day, and year) Jan. 11 1863

| 7 AGE | Years | Months | Days | IF LESS than 1 day ... hrs. or ... min. |
|---|---|---|---|---|
| | 63 | 1 | 26 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md.

PARENTS

10 NAME OF FATHER John Staley

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown.

14 Informant Peter Burns.

(Address) 1411 Battery ave.

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per ORR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6/27 19

17 I HEREBY CERTIFY, That I attended deceased from Feb 22 19 27 to March 6 19 27

that I last saw h alive on March 6 19 27

and that death occurred, on the date stated above, at 1000 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Enterocolitis 6

Nephritis. (duration) yrs. mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) John A. Ehrenfried M. D.

19 (Address) 1337 E. Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem. A. A. Co. Date of Burial 3/9 1927

20 UNDERTAKER Margaret P. Flynn ADDRESS 1422 Light St.

Spec.-7-17-26—A Co.—200 Bks.

E·19854

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19854

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 3851 Monastery Ave St. 23-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Kimball

(a) RESIDENCE NO. 128 W. Clement St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. J. Kimball.

6 DATE OF BIRTH (month, day, and year) Dec. 23rd 1872

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min.. |
|---|---|---|---|---|
| | 54 | 2 | 11 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in whirh employed (or employer)

(r) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER Peter Scully

11 BIRTHPLACE OF FATHER (City or town) Balto. Md.

(State or country)

12 MAIDEN NAME OF MOTHER Ann Maxwell

13 BIRTHPLACE OF MOTHER (city or town) Balto.

(State or country) Md.

14 Informant Wm. J. Kimball

(Address) 128 W. Clement.

15 Filed ..... 19 ..... C. HAMPSON JONES, M.D. Registrar

FEB - 1927 Per .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 15 1927 to Mar. 6 1927

that I last saw h alive on Mar 5 1927

and that death occurred, on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

Acute Heart

(duration) yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. — mos. 15 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. H. Kelly M. D.

19 (Address) 1340 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — Date of Burial March 9 1927

20 UNDERTAKER Margaret L. Flynn — ADDRESS 1422 Light St.

Spec.—8-24-14—M. & T.—2000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

19855

## CERTIFICATE OF DEATH.

94-004 E 19855

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1517 N Loudon St. 19-28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lewis Kalling

(Residence in Baltimore: No. 1517 N Loudon St.) 84 yrs., 3 mos. 23 ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, May 15, 1842 (Month) (Day) (Year)

7-AGE, 84 yrs. 3 mos. 23 ds. If LESS than 1 day, ....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore, Md

PARENTS.

10-NAME OF FATHER, Lewis Kalling

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. M. Kalling

(Address) 1517 N. Loudon St.

15-

Filed Mar. 10 1927 C. HAMPSON JONES, M. D. Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 7, 1927 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar 1 1927, to Mar 7 1927, that I saw him alive on Mar 7 1927, and that death occurred, on the date stated above, at 8.10 P.M.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(Duration) ... yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 3 yrs. ... mos. ... ds.

(Signed) J. A. Schaefer M. D.

Mar 7, 1927 (Address) 12 E. 25th

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery — DATE OF BURIAL, Mar. 10, 1927.

20-UNDERTAKER Joseph A. Cook — ADDRESS 1003 N. Gilmor St.

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19856

E 19856

## CERTIFICATE OF DEATH

REGISTERED NO. 162

1-PLACE OF DEATH Colonial Hospital

City of BALTIMORE: (No. 1122 North Mount St. 16 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lloyd Bosley, Jr.

(a) RESIDENCE NO. 1132 N. Fulton Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 25, 1927

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|---|
| | XXX | XXX | 11 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Lloyd Bosley

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Balto. Co., Md.

12 MAIDEN NAME OF MOTHER Rose Luckan

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant Lloyd Bosley

(Address) 1132 N. Fulton Ave

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D.

Per ..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/7 1927

17 I HEREBY CERTIFY, That I attended deceased from 2/28 1927 to 3/7 1927

that I last saw him alive on 3/7 1927

and that death occurred, on the data stated above, at 7:30 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia lobaris monstrosum

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) None

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) C. Hampson Jones, M. D.

3-7 . 19 27 (Address) 1132 N. Mount St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Interred Carroll Co. Md.

Date of Burial Mar. 9 1927

20 UNDERTAKER Joseph B. Cook

ADDRESS 1003 N. Eutaw St.

Very Important. See instructions on back of this

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

19857

100-001.

E 19857

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1611 Lind Hill a St., 14-20 Ward)

2-FULL NAME Paul E. Nixon

(a) RESIDENCE NO. 1611 Lind Hill a St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | C | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2-10-27

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | | | 25 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) Balto Md
(State or country)

10 NAME OF FATHER Albert E Nixon Canada

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Annie P. Gibson

13 BIRTHPLACE OF MOTHER (city or town) Frederick
(State or country) Oklahoma

14 Informant Annie P. Nixon
(Address) 1611 Lind Hill a

15 1927 C. HAMPSON JONES, M. D.
(Registrar)
Per Mrs

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5 — 19 27.

17 I HEREBY CERTIFY, That I attended deceased from March 3, 1927, to March 5, 1927, that I last saw h[e] alive on March 5, 1927, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Broncho. Pneumonia
(no Infectious disease)

(duration) yrs. mos. 2 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death? No

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Marcellus E Stone, M. D.

, 19 (Address) 1745 N Carey st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — Date of Burial: 3/8 1927

20 UNDERTAKER: Mrs Sol H. Dennis per T. E. Nelson — ADDRESS: 1303 Freeman St

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19858

## CERTIFICATE OF DEATH.

161-001

E 19858

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1378 N Caroline ST. 15-23 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Brown

(a) RESIDENCE NO. 1378 N. Caroline ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | Cn | Infant |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) Mch 6. 1927

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs. or ....min. |
|---|---|---|---|---|
| | | | 2 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓ none

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) 1378 N. Caroline

PARENTS

10 NAME OF FATHER Wm Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Helen Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Helen Brown
(Address) 1378 N. Caroline St

15 1927 C. HAMPSON JONES, M. D., Registrar
Per AWR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 8 1927

17

I HEREBY CERTIFY, That I attended deceased from Mch 6, 1927, to Mch 8, 1927

that I last saw h[illegible]alive on Mch 7, 1927

and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity - 2 months

(duration) yrs. mos 2 ds.

CONTRIBUTORY ✓
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Wm H Wright M. D.

Mch 8, 1927 (Address) 1209 Pleasant St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery — DATE OF BURIAL 3/9—1927

20 UNDERTAKER Mrs Jas. H Dennis Per T E Kelson — ADDRESS 1303 Pleasant St

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 19859

REGISTERED NO. 74001 E 19859

1-PLACE OF DEATH

City of BALTIMORE: (No. 3606 Clifton Ave St.) (Ward) 45-61

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara A. Swarty

(a) RESIDENCE NO. 3606 Clifton Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrye C. Swarty

6 DATE OF BIRTH (month, day, and year) Jan. 2 1858

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min.. |
|---|---|---|---|---|
| | 69 | 2 | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Indiana

PARENTS

10 NAME OF FATHER Charles A. Hancock

11 BIRTHPLACE OF FATHER (City or town) Balto.

(State or country) Md.

12 MAIDEN NAME OF MOTHER Amanda Kinnear

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Indiana

14 Informant Mrs. Carrye C. Swarty

(Address) 3606 Clifton Ave.

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 8 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 6 1926 to Mar 8 1927

that I last saw h[illegible] alive on Mar 7 1927

and that death occurred, on the date stated above, at 7.10 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, cerebral and general with cerebral hemorrhage and slow regression

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Respiratory failure and exhaustion (duration) yrs. 1 mos. — ds.

18 Where was disease contracted - -

If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Hayley Cale M. D.

(Address) 7 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery Date of Burial Mar 11 1927

20 UNDERTAKER Wm J Ricker Sons ADDRESS Norfolk Va

Very Important. Be particular to give full name of Father and Mother.

8

Martha C. (Wilcox)

Spec.—8-24-14—M. & T.—2000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19860 E 19860

## CERTIFICATE OF DEATH.

REGISTERED NO. C 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Gundry Sanatorium St.; 12-19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Martha C. Wilcox

(Residence in Baltimore: No. Maiden Lane Apts 20th Ave & Calvert St.; 40 yrs., 2 mos. 10 ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

| 3-SEX. | 4-COLOR OR RACE. | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) |
|---|---|---|
| Female | White | Widow |

6-DATE OF BIRTH, Dec (Month) 25 (Day), 1846 (Year)

7-AGE, 80 yrs. 2 mos. 10 ds. If LESS than 1 day, ....hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Lady
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Phila Pa

PARENTS.

10-NAME OF FATHER, Wm J Wilcox

11-BIRTHPLACE OF FATHER (State or Country). Phila Pa

12-MAIDEN NAME OF MOTHER Anna Malley

13-BIRTHPLACE OF MOTHER (State or Country). Phila Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Aida F McCarty

(Address) 143 E Northwood

15- Filed 8- 1927 C. HAMPSON JONES, M. D. 191 Registrar.

Per

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 7 (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 4 1904, to March 7 1927, that I saw h er alive on March 7 1927, and that death occurred, on the date stated above, at 7.30 p m.

The CAUSE OF DEATH* was as follows:

Senile Carcinoma Duodenum

1½ hrs

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(Duration) Several yrs. ....mos. ....ds.

(Signed) Stephen S. Conaway M. D.

March 7, 1927 (Address) Gundry Sanatorium Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 23 yrs. 2 mos. 3 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence Maiden Lane Apts Baltimore City

19-PLACE OF BURIAL OR REMOVAL. Greenmount Cemetery

DATE OF BURIAL. March 10th, 1927.

20-UNDERTAKER George Schilling & Sons

ADDRESS 1126 E Monument

Cor.—12-9-25—A Co.—200 Bks.

E 19861

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

7-12 129

E 19861

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1200 N. Collington Ave St., _____ Ward)

2-FULL NAME Paul C. Sloffer

(a) RESIDENCE NO. 1200 N. Collington St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine C. Sloffer

6 DATE OF BIRTH (month, day, and year) Sept 5/1872

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 54 | 6 | 1 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of indnstry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md.

(State or country)

PARENTS

10 NAME OF FATHER Frederick Sloffer

11 BIRTHPLACE OF FATHER (city or town)

(State or country) U.S.A.

12 MAIDEN NAME OF MOTHER Elizabeth Phill

13 BIRTHPLACE OF MOTHER (city or town) Balto., Md.

(State or country)

14 Informant Catherine C. Sloffer

(Address) 1200 N. Collington Ave

15 Filed 1927 G. HAMPSON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 6/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardialis Chr.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Nephrotis-hypertension

(duration) .....yrs. .....mos. .....ds.

(Signed) J. E. Evans M. D.

(Coroner)

3/8/27 (Address) 908 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Date of Burial March 11 1927

20 UNDERTAKER Geo. Schilling & Sons ADDRESS 1126 E. Monument

Spec.—1-12-23—M&T—500 Blks.

E 19862

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19862

## CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1523 Jackson ST. 24-34 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph A. Jefferson

(a) RESIDENCE NO. 1523 Jackson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | white | Widower |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catharine V. Jefferson

6 DATE OF BIRTH (month, day, and year) Oct 29-1839

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 87 | 4 | 8 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. Ord

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St. Michaels Md.

PARENTS

10 NAME OF FATHER John. Jefferson.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Rebecca Sobel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Miss Jefferson.

(Address) 1523 Jackson.

15 Filed 3-1927 C. HAMPSON JONES, M. D. Registrar

By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-7 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 17, 1926, to Mar 7th, 1927, that I last saw h— alive on Mar. 6th, 1927 and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs

(Signed) Wm. T. Seabury, M. D.

3/8, 1927 (Address) 626 Fort Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cemetery

DATE OF BURIAL 3/10 1927

20 UNDERTAKER J. Frew Mc Cully

ADDRESS 130 E. Fort

Spec.-7-17-26--A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19863

## CERTIFICATE OF DEATH

74-901.

E 19863

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1915 E. Pratt St. 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anastasia B. Moloney

(a) RESIDENCE NO. 1915 E. Pratt St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 ~~SEX~~ Female

4 Color or Race White

5 Single, Married, Widowed, or Divorced. (write the word) Widowed

5a If married, widowed, ~~or divorced~~

(or) WIFE of Wm. Moloney

6 DATE OF BIRTH (month, day, and year) Feb. 18-1847

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min.. |
|---|---|---|---|---|
| | 80 | | 17 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ireland

(State or country)

PARENTS

10 NAME OF FATHER Patrick Cleary

11 BIRTHPLACE OF FATHER (City or town) Ireland

(State or country)

12 MAIDEN NAME OF MOTHER Johanna Welsh

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Patrick Moloney

(Address) 1915 E Pratt St.

15 [illegible] 1927

Dat

C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 27.

May 5

17 I HEREBY CERTIFY, That I attended deceased from May 1, 19 27, to May 5, 19 27.

that I last saw h[illegible] alive on May 5, 19 27.

And that death occurred, on the data stated above, at 5 p. m.

The CAUSE OF DEATH* was as follows:

Cellulitis & Cachexia

(duration) yrs. mas. da.

CONTRIBUTORY (Secondary) Uraemia Chronic Nephritis

(duration) yrs. mos. 2 da.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

May 31, 19 27 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cemetery

Date of Burial 3/9/1927

20 UNDERTAKER J. G. Moran

ADDRESS 3006 E. Baltimore

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19864

## CERTIFICATE OF DEATH.

11-66 E 19864

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1324 W Lombard St., St., 19-29 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Blance Triplett

(a) RESIDENCE NO. 1324 W Lombard St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 6th 1920

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 7 | I | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolgirl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Dr. Wm. H. Triplett

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va.

12 MAIDEN NAME OF MOTHER Emma Arther

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Dr. Wm. H. Triplett
(Address) 1324 W Lombard St.

15 1927 C. HAMPSON JONES, M. D.
Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 1927

17 I HEREBY CERTIFY, That I attended deceased from March 5, 1927, to March 6, 1927, that I last saw h alive on March 5, 1927, and that death occurred, on the date stated above, at 130 m.

The CAUSE OF DEATH* was as follows:

Acute Dilated Tuberculosis

CONTRIBUTORY (Secondary) Acute Carditis Duration 4 ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings.

(Signed) Harry W. Dietz M. D.

, 19 (Address) 1315 Eutaw Royal Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery.

DATE OF BURIAL: March 19 27

20 UNDERTAKER: Harry H. Wirzke

ADDRESS: 1534 W. Lombard St.

pec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

19865 E 19865

## CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH St Joseph's Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Caroline & Oliver Sts ST. 12-50 WARD)

2-FULL NAME John Weil -

(a) RESIDENCE NO. 302 E. 21st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | white | Married |

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Anne M Weil

DATE OF BIRTH (month, day, and year) Oct 5 57-6

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 80 | 5 | | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoe Business

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Ernst P. Weil

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rosalie Ernst

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Mrs Anne Weil

(Address) 302 E 21st St

FILED 1927 M. C. HAMPSON JONES, M. D. Registrar

Per ARH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/8 1927.

17 I HEREBY CERTIFY, That I attended deceased from 2/9, 1927, to 3/8, 1927, that I last saw him alive on 3/8, 1927, and that death occurred, on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Prostatic Hypertrophy -

Chronic Cystitis Chr nephritis -

Arterio sclerosis

about 2

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia - Exhaustion -

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home Residence

Did an operation precede death? yes Date of 2/9/27

Was there an autopsy? no

What test confirmed diagnosis? Clinical Laboratory

(Signed) Clinton E Wagner, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Balto | DATE OF BURIAL 19 27

20 UNDERTAKER H. McCormick & Son | ADDRESS Eutaw

Spec.—12-9-25—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19866

## CERTIFICATE OF DEATH.

E 19866

1-PLACE OF DEATH

City of BALTIMORE: (No. 1414 Reynold St. 24-35 Ward) 90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Bush

(a) RESIDENCE NO. 1414 Reynold St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 Color or Race W.

5 Single, Married, Widowed, or Divorced, (write the word) M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm M Bush

6 DATE OF BIRTH (month, day, and year) Nov 18 - 1872

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 54 | 3 | 19 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Mass.

PARENTS

10 NAME OF FATHER John Kaffenburger

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Louisa Baker

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Wm M Bush

(Address) 1414 Reynold St

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 7. 1927.

17 I HEREBY CERTIFY, That I attended deceased from Jan 19, 1927, to Mar 7, 1927, that I last saw h[illegible] alive on Mar 6, 1927, and that death occurred, on the date stated above, at 7.05 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted —

If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) W. Deaver, M. D.

(Address) 626 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Date of Burial Mch 9 1927

20 UNDERTAKER Wm Cook ADDRESS 3012 E Monument

Spec.—12-9-25—A Co.—200 Blks.

E 19867.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-021

E 19867

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Mercy Hospital

City of BALTIMORE: (No. 11-15 St. (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Clements

(a) RESIDENCE NO. Belvedera Hotel Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M. | W. | Widower |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) About

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 56 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Kitchen Helper

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer Belvedere Hotel

9 BIRTHPLACE (city or town)

(State or country) Pa.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant John Crockett

(Address) 132 Eastwood

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 1927

17 I HEREBY CERTIFY, That I attended deceased from March 1 1927, to March 7 1927

that I last saw h— alive on March 7 1927

and that death occurred, on the date stated above, at 6:45 P. M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D Smith M. D.

1927 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

St. Mary's Cemetery Md 1927

20 UNDERTAKER ADDRESS

Wm Cook 932 N. Eutaw

Spec.—1-10-21—M&T—1500 Blks.

E 19868

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19868

## CERTIFICATE OF DEATH.

90

REGISTERED NO. 27-45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3436 Belair Road ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Selina Morgan

(a) RESIDENCE NO. 3436 Belair Road ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Napolion Morgan

6 DATE OF BIRTH (month, day, and year): May 7, 1853

7 AGE — Years: 73 — Months: 9 — Days: 29 — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: seamstress 069

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: James Ore

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Ellen Ore

13 BIRTHPLACE OF MOTHER (city or town) (State or country): md.

14 Informant: Mr. L. E. Kaufer

(Address): 3436 Belair Road

15 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 7, 1927, to March 7, 1927, that I last saw h e alive on March 1, 1927, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jacob Frohn, M. D.

3/7, 1927 (Address) 1823 N. Wash Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Airy, Md.

DATE OF BURIAL: Mar 9, 1927

20 UNDERTAKER: E. LeRoy Stafflebur

ADDRESS: 125 E North Ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

113

E 19869

CERTIFICATE OF DEATH

Curtis Bay

E 19869

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 544 Pennington st., 25 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George J. Kotchen

(a) RESIDENCE NO. 544 Pennington ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 18 1927

7 AGE: Years — Months — Days 18

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Curtis Bay, Balto

(State or country)

PARENTS

10 NAME OF FATHER: John D. Kotchen

11 BIRTHPLACE OF FATHER (city or town): Richmond, Va

(State or country)

12 MAIDEN NAME OF MOTHER: Annie Szczhac

13 BIRTHPLACE OF MOTHER (city or town): Austred

(State or country)

14 Informant (Address): John D. Kotchen 544 Pennington ave

15 Filed: 1927 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 8 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry.)

.....find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intestinal Indigestion

Duration: .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs. .....mos. .....ds.

(Signed) Thos. B. Forbes M. D.

Coroner

March 8 1927 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury; (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional items.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cem C.C. Date of Burial: March 9 1927

20 UNDERTAKER: Margin & Hynes ADDRESS: 1122 Light St.

Spec.–7-17-26—A Co.—200 Bks.

E 19870

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 19870

1-PLACE OF DEATH

City of BALTIMORE: (No. 1210 S. Third St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catharine Lardner

(a) RESIDENCE NO. 1210 S. Third St. 26 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. 5 mos. 19 ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 16th 1901

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min.. |
|---|---|---|---|---|
| | 25 | 5 | 19 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Invalid

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER John Lardner

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ireland.

12 MAIDEN NAME OF MOTHER Katherine Bryan

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Katharine Lardner

(Address)

15 Filed ..... 19 .....

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7th 1927

17 I HEREBY CERTIFY, That I attended deceased from 9/15, 1926 to 3/8, 1927, that I last saw h[illegible] alive on 3/3, 1927, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Idiocy.

(duration) 25 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 3 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

3/8, 1927 (Signed) J. H. Garrell M. D.

(Address) 633-5-34

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Cathedral Cemetery | March 9th 1927 |
| 20 UNDERTAKER Lilly-Zeiler | ADDRESS 403 S. Woods St |

MAR 9 - 1927 C. HAMPSON JONES, M. D. Registrar

By [illegible]

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19871

## CERTIFICATE OF DEATH.

E 19871

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Howard A. Kelly Hospital ST., [illegible] WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Delia Margaret Davis.

(a) RESIDENCE NO. 417 W. 120 ST., WARD New York, N.Y.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? 60 yrs. — mos. — ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

3 If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

DATE OF BIRTH (month, day, and year) July 4 1860

| AGE | Years | Months | Days | If LESS than 1 day, ..... hrs or ..... min. |
|---|---|---|---|---|
| | 66 | 8 | 4 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Milliner & Dressmaker

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

BIRTHPLACE (city or town) Saint Liss
(State or country) Canada

10 NAME OF FATHER Thomas David Davis

11 BIRTHPLACE OF FATHER (city or town) Saint Liss
(State or country) Canada

12 MAIDEN NAME OF MOTHER Jennie White

13 BIRTHPLACE OF MOTHER (city or town) Saint Liss
(State or country) Canada

14 Informant Dr Charles E. Davis
(Address) Albany New York

15 Filed ....., 19 C. HAMPSON JONES, M.D. Registrar

MAR 29 - 1927

By [illegible]

N. B.—WR... mation ... CAUSE ... TION is ...

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8 1927.

17

I HEREBY CERTIFY, That I attended deceased from Nov. 3, 1926, to March 8, 1927.

that I last saw h alive on March 8, 1927.

and that death occurred, on the date stated above, at 11 1/2 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of urinary bladder

(duration) yrs. 9 mos ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? No. Date of —

Was there an autopsy? Partial

What test confirmed diagnosis? Biopsy

(Signed) Robert E. Fowler, M. D.

, 19 (Address) 1418 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Albany New York — DATE OF BURIAL: March 9 1927

20 UNDERTAKER: Chas. G. Black — ADDRESS: 742 W. North ave.

Spec.—1-10-21—M&T—1500 Bks.

19872

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 19872

1-PLACE OF DEATH Balto City Hospls

CITY OF BALTIMORE: (No. Balto Md St., 25-15 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Green

(a) RESIDENCE No. 219 S. 1st St. Brooklyn St. Md Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE: Years 52 Months Days

If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 0 16

(b) General nature of industry, business, or establishment in which employed (or employer) Mill work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Martha Brothers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Balto City Hospls (Address) Balto Md

15 Filed MAR 9 - 1927 T. HAMPTON JONES, M. D. Registrar Per [illegible]

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-7 1927

17 I HEREBY CERTIFY, That I attended deceased from 2-7, 1927 to 3-7, 1927 that I last saw him alive on 3-6-, 1927 and that death occurred, on the date stated above, at 3 20 A m.

The CAUSE OF DEATH* was as follows:

Terminal Broncho Pneumonia

Acute and chornic Myocardial Insufficiency; chronic nephritis (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Psychosis with Cardio Renal Insufficiency. (duration) yrs mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Harry Todd Smith M. D.

19 [illegible] (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Forest Grove Md DATE OF BURIAL March 9 1927

UNDERTAKER D. Davis & Son ADDRESS 1916 Pa ave

Spec.—1-12-23—M&T—500 Blks.

E 19873

# HEALTH DEPARTMENT—CITY OF BALTIMORE

06-001

## CERTIFICATE OF DEATH.

Brooklyn E 19873

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 105 Patapsco Ave. WARD 15-15)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie E Talbott

(a) RESIDENCE NO. 105 Patapsco Ave ST., ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. 9 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | W | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 30 1924

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | | 9 | 7 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John C Talbott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Annie M McAdams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant John C Talbott (Address) 105 Patapsco Ave

15 Filed ..... 19.. HAMILTON JONES, M. D. Registrar

APR - 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 15, 1927, to Mar 7, 1927 that I last saw h~~e~~ alive on Mar 7, 1927 and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

Primary (duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. H. Campbell M. D.

Mar 8, 1927 (Address) 164 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Holy Cross | Mar 9 1927 |

20 UNDERTAKER John F Denny ADDRESS 715 Light St

Cor.—12-9-25—A Co.—200 Bks.

E 19874

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

101-001

E 19874

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 105 W. York St. St. 22-30 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Smith.(C)

(a) RESIDENCE NO. 105 W. York St. St._____ Ward 26.

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 2 mos. — ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male. | Colored | Single. |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) March 18, 1920

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 6 | 11 | 14 16 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. ND

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) South Carolina

PARENTS

10 NAME OF FATHER John Smith.(C)

11 BIRTHPLACE OF FATHER (city or town)

(State or country) South Carolina

12 MAIDEN NAME OF MOTHER Ethel Parker.(C)

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) South Carolina

14 Informant John Smith.(C)father)

(Address) 105 W. York St.

15 Filed MAR 9 - 1927 C. HAMILTON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4, 1927 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) Otto M. Feinhandt M. D. (Coroner)

7/8 · 19 27 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. Date of Burial Mar 7 1927

20 UNDERTAKER H. R. Braun's Son ADDRESS 1501 N. Howard

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19875

## CERTIFICATE OF DEATH.

100-001

E 19875

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4000 Lewin Av ST. 15-63 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Dora Rosenberg

(a) RESIDENCE No. 4000 Lewin ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | white | widow |

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Rosenberg

7 DATE OF BIRTH (month, day, and year) Unknown

| 8 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 69 | — | — | |

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

10 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Simon Rosenthal

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Canada

14 Informant (Address) Jack Lewis 1439 E Baltimore St

15 Filed ..... 19 ..... Registrar

MAR 3 - 1927 HARRISON JONES M

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9 1927

17 I HEREBY CERTIFY, That I attended deceased from March 6th, 1927, to March 9th, 1927, that I last saw h alive on March 8th, 1927 and that death occurred, on the date stated above, at 1.15 P m

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & symptoms

(Signed) Harry N. Schmidt M.D., M. D.

, 19 (Address) 3704 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [redacted] Herman Kuhn

DATE OF BURIAL 3/9 1927

20 UNDERTAKER Jack Lewis 1439 E Balto St

ADDRESS

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

# CERTIFICATE OF DEATH

E 19876 — 129 — E 19876

1-PLACE OF DEATH — Near 7 Mile Lane — REGISTERED NO. 2755

City of BALTIMORE: (No. 6009 Shelburne Ave St.) (Ward) — (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice S. Frock.

(a) RESIDENCE NO. 6009 Shelburne Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | White | Widow |

5a If ~~married, widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of John Frock.

6 DATE OF BIRTH (month, day, and year) February 20 1857

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min.. |
|---|---|---|---|---|
| | 70 | — | 17 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Levi Rock.

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Mary C. Manning

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Pennsylvania

14 Informant Mrs Marion Baumgardner

(Address) 6009 Shelburne Ave

15 Filed MAR 9 - 1927 19 C. HAMPTON JONES M.D. Registrar

Per

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) MAR 7 1927 19

17 I HEREBY CERTIFY, That I attended deceased from March 2, 1927, to March 7, 1927, that I last saw h alive on March 4, 1927, and that death occurred, on the date stated above, at 7:30 a m.

The CAUSE OF DEATH* was as follows:

Mitral Asthenic Regurgitation

Pleural Anasarca

Ch. Nephritis

(duration) yrs. ? mos ds.

CONTRIBUTORY Asthenia (Secondary)

(duration) yrs. mos 6 ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry McCleary, M. D.

3/7, 1927 (Address) 400 N Clayton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Littlestown Penna — Date of Burial MAR 10 1927 19

20 UNDERTAKER Geo W Little — ADDRESS 2708 Edmondson Ave

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19877

## CERTIFICATE OF DEATH.

129 ✓ E 19877

REGISTERED NO.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St., 3-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kathe Short

(a) RESIDENCE NO. 35 South Bond St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Negro | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None.

6 DATE OF BIRTH (month, day, and year) 1892

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 35 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Factory Work

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ?

(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?

(State or country)

14 Informant BALTIMORE CITY HOSPITALS

(Address) Records

MAR 9 - 1927 Filed HAMILTON JONES, M. D. Registrar

For

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5 1927

17

I HEREBY CERTIFY, That I attended deceased from February 20, 1927, to March 5, 1927, that I last saw her alive on March 5, 1927, and that death occurred, on the date stated above, at 10 10 A.M.

The CAUSE OF DEATH* was as follows:

Epilepsy (idiopathic)

Chronic Interstitial Nephritis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? general & factory

(Signed) R Hooper Smith, M. D.

March 12 1927 BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury cemetery Date of Burial March 9 1927

UNDERTAKER Milton Davis ADDRESS 316 N Eden St

Spec—12-23-21—E.B.R.S.—400 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 19878

E 19878

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

15-63

Registered No.....

City of BALTIMORE: (No. 3706 Liberty Heights Ave. St., ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Reid Hayden

(a) Residence No. 3706 Liberty Heights Ave St., ..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-(Married, Widowed, or Divorced) (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or WIFE of) Nellie Silver Hayden

6-DATE OF BIRTH (month, day and year) July 8, 1885

7-AGE. 41 yrs. 7 mos. 27 ds. If LESS than 1 day, ....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Manager

(b) General nature of industry, business, or establishment in which employed (or employer): Pipe + other manufacturing

(c) Name of employer: W. Reid Hayden Inc.

9-BIRTHPLACE (city or town) Baltimore (State or Country), Maryland

PARENTS:

10-NAME OF FATHER, George C. Hayden

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Jennie Reid

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ohio

14- (Informant) Nellie Silver Hayden
(Address) 3706 Liberty Heights Ave

15- Filed ..... 193 ..... C. HAMPTON JONES, M. D. Registrar.

MR - 1927 R.H.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 7, 1927

17- I HEREBY CERTIFY, That I attended deceased from Mar. 6 1927 to Mar. 7 1927 that I last saw h[er] alive on Mar 7 1927 and that death occurred, on the date stated above, at 6:30 P m.

The CAUSE OF DEATH* was as follows:

Acute Pneumonia
(Broncho-pneumonia)

(Duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Toxemia. Ac. respiratory failure (Duration) ..... yrs. ..... mos. 2 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Carroll Pollard M. D.

March 8, 1927 (Address) 4 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19-PLACE OF BURIAL, CREMATION OR REMOVAL. | DATE OF BURIAL. |
|---|---|
| Greenmount Cemetery | March 10, 1927 |

| 20-UNDERTAKER. | ADDRESS |
|---|---|
| J. Aughenbaugh Jones Inc. | 424 N. Broadway |

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

19879

## CERTIFICATE OF DEATH.

182

E 19879

REGISTERED NO.

1-PLACE OF DEATH Uplands

City of BALTIMORE: (No. Old Frederick Road St. 28-7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alexander Carson Councill

(a) RESIDENCE NO. Uplands, Old Frederick Rd. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Single |

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 27, 1853

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 73 | 7 | 10 8 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Caretaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mr. Ferguson

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER James G. Councill

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Sara White

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant Robert Councill

(Address) Arbutus, Md.

15 Filed MAR 3-8 1927 HAMPTON JONES, M. D. Registrar

MAR - 1927

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7, 1927 193

17 I HEREBY CERTIFY That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry) thereon and from the evidence obtained Investigation, autopsy or inquiry.) And that said deceased came to h[illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows: Accidental Drowning

Unknown

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) fell in well - missing 5 days before found

(Duration) yrs. mos. ds.

(Signed) Thos. Burton M. D.

(Coroner)

3-8, 1927 (Address) Cedar & Curtis Ave.

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

Cerebral Hem. Back Yard

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. Date of Burial Mar 9 1927

20 UNDERTAKER Joseph L. Cook ADDRESS 1003 Pulaski St

pec.—1-12-23—M&T—500 Bks.

Beck.

8676

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

38 E 19880

E 19880

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSP ST., 9-46 WARD)

2-FULL NAME Irene J Beck

(a) RESIDENCE NO. 1633 E. 33rd St City WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | White | |

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) June 10/26

| AGE | Years | Months | Days | If LESS than 1 day, hrs or min |
|---|---|---|---|---|
| | | 8 | 27 28 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md -

PARENTS

10 NAME OF FATHER Henry Beck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md -

12 MAIDEN NAME OF MOTHER Bessie Frazier

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md -

14 Informant Records -

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 1927 H. HAMILTON JONES, M. D. Registrar Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 1927

17 I HEREBY CERTIFY, That I attended deceased from March 6 1927 to March 7 1927

that I last saw her alive on March 7 1927

and that death occurred, on the date stated above, at 5 55 P m

The CAUSE OF DEATH* was as follows:

Syphilis, early hereditary

(duration) yrs. Life ds.

CONTRIBUTORY (Secondary) Primary Pneumonia/Bronchos

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? 1633 E 33rd St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. E. Handley, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood — DATE OF BURIAL 3/4 1927

20 UNDERTAKER Philip Henry — ADDRESS 2016 Eutaw

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

19881

## CERTIFICATE OF DEATH.

101-001 E 19881

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 402 E 20th St., (St.) 12-19 (Ward)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah M. Simmons.

(a) RESIDENCE NO. 402 E 20th St. ST. WARD
(Usual place of abode)
Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | widow |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of late Frank G. Simmons

6 DATE OF BIRTH (month, day, and year) Aug. 24, 1854

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 72 | 6 | 10 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Thomas Waddell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Booth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Richard Simmons
(Address) 1532 N Milton Ave.

15 Filed 9-1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 26 1927, to March 6 1927.
that I last saw h[illegible] alive on March 6 1927.
and that death occurred, on the date stated above, at 4.55 P m.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Jos W. Applegarth III M. D.

3/8/1927 (Address) 401 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cemetery — DATE OF BURIAL: March 9 1927

20 UNDERTAKER: Harry A. Witzke — ADDRESS: 531 W. Lombard St

Spec.—7-17-26—A Co.—200 Bks.

19882

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

90 E 19882

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1529 N. Bond St. 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Loretta Marie Otto

(a) RESIDENCE NO. 1529 N. Bond St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 29-1902

7 AGE: Years 24 Months 11 Days 8 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town): Baltomd

(State or country)

PARENTS

10 NAME OF FATHER: Charles A. Otto

11 BIRTHPLACE OF FATHER (City or town): Baltomd

(State or country)

12 MAIDEN NAME OF MOTHER: Frances M. Strohmer

13 BIRTHPLACE OF MOTHER (city or town): Baltomd

(State or country)

14 Informant: Charles A. Otto

(Address): 1529 N. Bond St.

15 Filed MAR 9 - 1927 19 E. HAMPTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 7 19 27

17 I HEREBY CERTIFY, That I attended deceased from for about 6 year 4 mths 3-27 19 ..... to 19 .....

that I last saw her alive on March 4 19 27.

and that death occurred, on the date stated above, at 6 P.M. m.

The CAUSE OF DEATH* was as follows:

Valvular disease heart

Some yrs (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted —

If not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) W. F. Tolley, M. D.

Mar 9 19 27 (Address) 16 Bay Riverdale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — Date of Burial: 3/10 19 27

20 UNDERTAKER: Chas. P. Graul & Son — ADDRESS: 1811 N. Charles St.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19883

## CERTIFICATE OF DEATH.

90 E 19883

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1603 E Madison ST., 7-13 WARD)

2-FULL NAME Anna May Harrison

(a) RESIDENCE NO. 1603 E Madison ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | C | Married |

5a If married, widowed, or divorced (or) WIFE of Issac Harrison

6 DATE OF BIRTH (month, day, and year) Aug. 31 1889

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or ... min. |
|---|---|---|---|---|
| | 37 | 6 | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Chas Henry

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Laura Jones

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1927. to March 7. 1927.

that I last saw h alive on March 6. 1927.

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency and Auricular Fibrillation

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R. J. Young, M. D.

19 (Address) 1429 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

14 Informant Saddie Churchill (sister)
(Address) 1603 Madison ave

15 Filed 19 Per Registrar

C. HAMPSON JONES, M. D.

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem

DATE OF BURIAL 3-13 1927

20 UNDERTAKER Jas. W. Skinner

ADDRESS 1021 N. Mad Ave

RG - 1927

Spec.—1-10-21 M&T 1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19884

## CERTIFICATE OF DEATH.

2/E 19884

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 221 S Stricker ST., 19-27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ezra Earle

(a) RESIDENCE NO. 221 S Stricker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 26 1908

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs or ....min. |
|---|---|---|---|---|
| | 18 | 8 | 11 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Frederick Earle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wheeling W. V.

12 MAIDEN NAME OF MOTHER Annie Zammack

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Annie Earle

(Address) 221 S Stricker st

15 Filed MAR 9 - 1927 HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/7- 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 24, 1927, to Mar 7 - , 1927.

that I last saw h alive on Mar 7 - , 1927.

and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Dont know

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas A Reehm, M. D.

3/7, 1927 (Address) 2105 N Balto st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Mar 10 1927

20 UNDERTAKER: John F Eilbs — ADDRESS: 1200 N Lombard st

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19885

## CERTIFICATE OF DEATH.

E 19885

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2108 Herbert St ST., 15-68 WARD)

REGISTERED NO. 10-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Louise Burns

(a) RESIDENCE No. 2108 Herbert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Nov 22 1920

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 7 | 3 | 13 16 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Thos James Burns

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Viola Lawrence

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant J. J. Burns

(Address) 2108 Herbert st

Filed 1927 C. HAMPTON JONES, M. D. Registrar

Per R.F.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8 — 1927

17 I HEREBY CERTIFY, That I attended deceased from March 7 — , 1927 , to March 8 — , 1927 , that I last saw her alive on March 8 — , 1927 , and that death occurred, on the date stated above, at 12-40 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Acute)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Viola Lawrence M. D.

3/8, 1927 (Address) 2004 W. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL 3/9. 1927

20 UNDERTAKER L. Linson & Bro

ADDRESS 1126 W. North ave

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 19886

## CERTIFICATE OF DEATH

E 19886

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 2164 Woodbury Ave. Ward 13-5)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lester Gorham.

(a) RESIDENCE NO. 2164 Woodbury Ave. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Sept 15, 1852.

7 AGE: Years 74 Months 5 6 Days 22 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Canada.

(State or country)

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Unknown.

14 Informant: Mrs. James Blair

(Address) 2164 Woodbury Ave.

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 March 7,

17 I HEREBY CERTIFY, That I attended deceased from March 2, 1927, to March 7, 1927,

that I last saw him alive on March 7, 1927,

and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Osculation & Percussion

(Signed) Jason F. Corry, M. D.

3/8, 1927 (Address) 4 Howard Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Montreal Canada

Date of Burial: March 9 1927

20 UNDERTAKER: Chenoweth Odon.

ADDRESS 3615 Chestnut Ave

Spec. -7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19887

## CERTIFICATE OF DEATH

101-001 E 19887

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Clarkes Lane, Arlington St., 28-63 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Miller

(a) RESIDENCE NO. Clarkes Lane, Arlington St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mollie Miller

6 DATE OF BIRTH (month, day, and year) March 23, 1864

| 7 AGE | Years | Months | Days | IF LESS than 1 day ...hrs. or ...min.. |
|---|---|---|---|---|
| | 62 | 11 | 16 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) B. & O.R. R.

(c) Name of employer

9 BIRTHPLACE (city or town) Elkridge

(State or country) Maryland

PARENTS

10 NAME OF FATHER John Miller

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Miss Klausmyer

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Charles Schwatka

(Address) Clarkes Lane, Arlington

Filed Mar 9 1927 C. HAMPSON JONES, M. D. Registrar

By RM

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from March 1— 1927 to March 8 1927

that I last saw him alive on March 7 1927

and that death occurred, on the date stated above, at 8:15 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Lobar Right Upper)

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Cardiac Dystrophy — Mitral Regurgitation

(duration) yrs. mos ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thomas A. Hafer M. D.

3-8. 1927 (Address) Sudbrook Avenue Pikesville, Md.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Stone Chapel Cemetery — Date of Burial: Mar. 10 1927

20 UNDERTAKER: Joseph L. Cook — ADDRESS: 1003 W. Mulberry St.

Spec.—12-9-25—A Co.—200 Bks.

Housell J Foster

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 19888

## CERTIFICATE OF DEATH.

E 19888

REGISTERED NO.

1-PLACE OF DEATH Mercy Hospital

City of BALTIMORE: (No. 27-55 St. 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hamel J Foster

(a) RESIDENCE NO. 5249 Linden Heights Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Bessie Foster

6 DATE OF BIRTH (month, day, and year): Unknown 1887

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 40 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Unclad R R 4 6 76

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Virginia

PARENTS

10 NAME OF FATHER Luther Foster

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Va

12 MAIDEN NAME OF MOTHER Frida Carter

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Va

14 Informant: Mrs Savanna C Foster

(Address) 1965 Rebecca St

15 Filed MAY 4 1927 C. HAMPTON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 8 1927.

17 I HEREBY CERTIFY, That I attended deceased from March 6, 1927, to March 7, 1927, that I last saw h.. alive on March 7, 1927, and that death occurred, on the date stated above, at 8:30 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis & Uraemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H Mullotta, M. D.

. 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — Date of Burial: May 10 1927

20 UNDERTAKER: Rida Windfield — ADDRESS: 714 Gramt Pl

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19889

## CERTIFICATE OF DEATH.

90 E 19889

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 533 N. Luzerne St., 7-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles A. Bauer

(a) RESIDENCE NO. 533 N. Luzerne St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Mail

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 10 1851

7 AGE: Years 76 | Months | Days 26 28 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cooper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER Adam Bauer

11 BIRTHPLACE OF FATHER (city or town) _____ (State or country) Ger.

12 MAIDEN NAME OF MOTHER Schneider

13 BIRTHPLACE OF MOTHER (city or town) _____ (State or country) Ger.

14 Informant Mrs. Rose Bauer (Address) 533 N. Luzerne

15 Filed _____ 19____ C. HAMILTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8, 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 23, 1927, to March 5, 1927, that I last saw him alive on March 5, 1927, and that death occurred, on the date stated above, at 1.15 p.m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) .....yrs. 4 mos. .....ds.

CONTRIBUTORY (Secondary) .....

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted —

If not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Henry T. Collenberg M. D.

3/8, 1927 (Address) 904 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Date of Burial March 11 1927

20 UNDERTAKER Jos. J. Kerr ADDRESS 106 N. Luzerne

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

19890

## CERTIFICATE OF DEATH.

179 E 19890

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 722 E. Preston ST. 9-18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Anna Pritchard

(a) RESIDENCE NO. 722 E. Preston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or ~~Divorced~~, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6 DATE OF BIRTH (month, day, and year): Nov 4, 1831

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 95 | 4 | 3 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): "

(c) Name of employer: "

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: James Pritchard

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary McKinney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Miss D. Haines

(Address): 722 E. Preston St

15 Filed MAR 9 - 1927 H. HAMPSON JONES, M. D. Registrar

Per [illegible]

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May. 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 27, 1927, to Mar. 7, 1927, that I last saw he alive on Mar. 6 - 1927, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Nephritis (Chronic)

(duration) Not definite yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Benj. D. Hayden, M. D.

3/9/1927 (Address) 1216 N. Carolina St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: Mar 9 1927

20 UNDERTAKER: John B Spencer — ADDRESS: 1316 N Carolina

Cor.—12-9-25—A Co.—200 Bks.

E 19891

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

15-21

1927 E 19891

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore General Hospital Ward)

(If death occurred in a bospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lee Burton.(C)

(a) RESIDENCE NO. 1506 N. Stricker St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. --- mos. --- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male. | Colored | Single. |

3a If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) March 1, 1897

| 7 AGE | Years | Months | Days | IF LESS than 1 day....hrs. or....min. |
|---|---|---|---|---|
| | 30 | 0 | 8 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) Standard Guano Co.

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia.

PARENTS

10 NAME OF FATHER John Burton.(C)

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia.

12 MAIDEN NAME OF MOTHER Mary E. Bunting.(C)

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia.

14 Informant Sarah Fisher.(C) sister.

(Address) 1506 N. Stricker St.

15 Filed 1927 G. HAMPTON JONES, M. D., Registrar

Per

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Occidental asphyxiation guano fumes, Occidental fall in ship's hold, fractured back, Traumatic pneumonia.

(duration) ...yrs. ...mos. 24 ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

(Signed) Otto M. Reinhardt M. D. (Coroner)

3/3, 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Standard Guano Co. Curtis Bay. Feb 9/27

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hamilton VA North Hamptam. Date of Burial March 10, 1927

20 UNDERTAKER Adolphus Halsted ADDRESS 90 N. Eutaw

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19892

## CERTIFICATE OF DEATH.

99-002

GE 19892

REGISTERED NO. 15-54

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2518 Penna. Ave ST., 15 WARD)

2-FULL NAME Milton Deridiss

(a) RESIDENCE NO. 2518 Penna. Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widowed |

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Amanda Deridiss

6 DATE OF BIRTH (month, day, and year) July 8 1844

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs or ... min. |
|---|---|---|---|---|
| | 83. | 7 8. | 29 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Frederick Deridiss

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Kaylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Margaret E. Warehime
(Address) 2518 Penna. Ave

15 Filed ... 19 1844 HAMPSON JONES, M. D. Registrar
Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1926 to March 7 1927.
that I last saw him alive on March 7 1927.
and that death occurred, on the date stated above, at 9.45 P m.

The CAUSE OF DEATH* was as follows:

Senile debility and
Cerebral Hemorrhage

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion
(duration) yrs. 1 mos. da.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Fred L Jewett, M. D.

19 (Address) 2546 Pennsylvania

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Westminster Cem. | March 1927 |
| 20 UNDERTAKER Joseph Ryder | ADDRESS North Ave |

Spec.—1-12-23—M&T—500 Blks.

John A Klotz

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19893

## CERTIFICATE OF DEATH.

100-001

E 19893 REGISTERED NO.

1-PLACE OF DEATH St Josephs Hospital. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Caroline & Oliver St. 26-42 WARD)

2-FULL NAME John August Klotz

(a) RESIDENCE NO. Radick & Franklin Ave. Belair Road. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M. | White | Widowed |

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown.

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 70 | — | — | |

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer) Farm

(c) Name of employer Radecke Bros.

8 BIRTHPLACE (city or town) Unknown

(State or country) Unknown

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown

(State or country) Unknown

14 Informant William Radecke

(Address) Raspeburg Md.

15 Filed 3-1321 C. HARRISON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 27, 1927, to March 7, 1927, that I last saw him alive on March 7, 1927, and that death occurred, on the date stated above, at 8:45 p. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia -

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? — Date of —

Was there an autopsy? None.

What test confirmed diagnosis? Clinical.

(Signed) Clement R. Worrell. M. D.

, 19 (Address) St Joseph's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Holy Redeemer Cemetery | March 10, 27 |
| 20 UNDERTAKER | ADDRESS |
| Frederick Beaumont | Sons Pulaski |

Cor.—12-9-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19894

E 19894

## CERTIFICATE OF DEATH.

17-26 74-001

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 701 Harlem Ave St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James E. Coates

(a) RESIDENCE NO. 701 Harlem Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | colored | widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 4, 1870

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| 56 57 | | 10 | 5 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cement Worker

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Wm. Coates

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Annie Owens

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Joseph Coates

(Address) 1412 Woodyear

15 Filed 1927 Per HARRY JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

cerebral hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) no other

(duration) yrs. mos. ds.

(Signed) J. J. Kenney M. D. (Coroner)

March 8, 1927 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery — Date of Burial Mar 9, 1927

20 UNDERTAKER Mr. Kate R. Williams — ADDRESS 322 N. Schroeder St.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19895

# CERTIFICATE OF DEATH.

90E 19895

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St., 18 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Herod

(a) RESIDENCE NO. 1109 Sarah Ann St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Negro | ? |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1866
January 10

| 7 AGE | Years | Months | Days | IF LESS than 1 day..... hrs. or.....min. |
|---|---|---|---|---|
| | 60 | 1 | 26 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant BALTIMORE CITY HOSPITALS

(Address) Records

15 Filed MAR 9 - 1927 No. Per C. HAMILTON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 1927

17

I HEREBY CERTIFY, That I attended deceased from August 20, 1925, to March 6, 1927, that I last saw him alive on March 5, 1927, and that death occurred, on the date stated above, at 3:45 A m.

The CAUSE OF DEATH* was as follows:

Senility

Chronic Myocarditis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. 2 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? general & laboratory

(Signed) R. Thompson Smith, M. D.

Mar (6) 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Mt. Auburn Cemetery — Mar 10, 1927

20 UNDERTAKER — ADDRESS

Mrs. Katie R. Williams — 4 Schroeder St

Spec.—1-12-23—MAT—500 Bks.

200833 Rec-

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

100-001 E 19896

REGISTERED NO. E 19896

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSP ST. 5-6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude Thompson

(a) RESIDENCE No. 1136 Comet St. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 11 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Mar 29 1926

7 AGE: Years: — Months: 11 Days: 8 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Wade Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country): NC

12 MAIDEN NAME OF MOTHER: Sadie Waters

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Records

(Address) JOHNS HOPKINS HOSP.

15 Filed 1927 C. HARTON JONES, M. D. Registrar

By RK

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 7 - 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 4, 1927, to Mar 7, 1927, that I last saw h[illegible] alive on Mar 7, 1927 and that death occurred, on the date stated above, at 5 P. M.,

The CAUSE OF DEATH* was as follows:

acute Primary Pneumonia

Bronchopneumonia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No 11 Comet St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. E. Handley, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: asbury cemetery — DATE OF BURIAL: Mar 8 1927

20 UNDERTAKER: Edward Bryan — ADDRESS 1691 orleans st

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19897

## CERTIFICATE OF DEATH.

161-002

E 19897

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1715 - Pennington Ave. ST., 75-77 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leroy Burkhardt.

(a) RESIDENCE NO. 1715 - Pennington Ave ST., 26 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single. |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) Mar. 8-1927.

| 7 AGE | Years | Months | Days | If LESS than 1 day ... hrs. ... min. |
|---|---|---|---|---|
| | | | | 7 hrs 15 min. |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant.

(h) General nature of industry, business, or establishment in which employed (or employer) Infant.

(c) Name of employer Infant.

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Frank J. Burkhardt.

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Amanda Lenhardt.

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Frank J. Burkhardt.
(Address) 1715 Pennington Ave.

Filed MAR 9 - 1927, 19

C. HAMPSON JONES, M. D.
Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar. 7, 1927, to Mar. 7, 1927, that I last saw him alive on Mar. 7, 1927 and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage - accident to Childbirth. 3 hrs 15 m

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? None

What test confirmed diagnosis? —

(Signed) Wm Ufford, M. D.

Mar 8, 1927 (Address) 846 - Pennington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery DATE OF BURIAL Mar 9 1927

20 UNDERTAKER George L. Schwab ADDRESS 1101 Eutaw St.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 19898 — 1-PLACE OF DEATH

161-027

E 19898 — REGISTERED NO.

City of BALTIMORE (No. 1021 Patapsco St. 23-33 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant of Mr & Mrs Raymond J. Maurer

(a) RESIDENCE NO. 1021 Patapsco St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year): Mar 8 1927

7 AGE — Years | Months | Days | IF LESS than 1 day 7 hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country) Md

PARENTS

10 NAME OF FATHER Raymond J. Maurer

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country) Md

12 MAIDEN NAME OF MOTHER Martha A. Mentzer

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md

14 Informant Raymond J. Maurer

(Address) 1021 Patapsco St.

Filed ..... 19 C. HAMPSON JONES, M. D.

By ..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 8 1927

17

I HEREBY CERTIFY, That I attended deceased from Mar 8, 1927, to Mar 8, 1927, that I last saw h~~e~~ alive on Mar 8, 1927, and that death occurred, on the date stated above, at 11-45 A. m.

The CAUSE OF DEATH* was as follows:

Abnormal Premature labor (Premature Con)

(duration) ... yrs. ... mos. ... / ... ds.

CONTRIBUTORY (Secondary) Asphyxia

(duration) ... yrs. ... mos. ... / ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. C. H. Campbell, M. D.

Mar 8, 1927 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — Date of Burial: March 19 27

20 UNDERTAKER: T. C. Strauss & Son — ADDRESS: 603 Hanover St

Spec.—12-9-25—A Co.—200 Bks.

E 19899

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 E 19899

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. (C. B.) Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Liston Wells

(a) RESIDENCE NO. 1307 Harlem ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1905

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 22 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Presser

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) North Carolina

PARENTS

10 NAME OF FATHER James Wells

11 BIRTHPLACE OF FATHER (city or town) Wallace

(State or country) North Carolina

12 MAIDEN NAME OF MOTHER Laura Newkirk

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Hospital Records

(Address)

15 C. HAMSON JONES, M. D.

1927 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 March 6, 1927

17

I HEREBY CERTIFY, That I attended deceased from June 23, 19 26, to March 6, 19 27,

that I last saw him alive on March 6, 19 27,

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. E. Gatlend, M. D.

3-7-27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wallace N. C. Mach 3rd 1927

Date of Burial

20 UNDERTAKER Daniel Easton Co

ADDRESS 916

Spec.—12-9-25—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19900

## CERTIFICATE OF DEATH.

7400-001

E 19900

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS 37

City of BALTIMORE: (No. [redacted] St. 16 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Ernst

(a) RESIDENCE NO. Rosedale, Balto. Co. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1844

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 83 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Heinrich Kattendorn

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Sophie ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant BALTIMORE CITY HOSPITALS

(Address) Records

15 Filed MAR 9 1927, 19 HARRY JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 1927

17

I HEREBY CERTIFY, That I attended deceased from March 2, 1927, to March 7, 1927, that I last saw h[illegible] alive on March 6, 1927, and that death occurred, on the date stated above, at 6 30 m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Laboratory

(Signed) R. Hooper Teutt M. D.

March 9 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schwartz Lemke Date of Burial 3/9 1927

20 UNDERTAKER J J Moran ADDRESS 3000 E Balto

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19901

## CERTIFICATE OF DEATH.

90 E 19901

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 206 N. Chase St. St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Smith

(a) RESIDENCE NO. 206 N. Chase St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | colored | single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1862

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| 65 | 55 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER Samuel Smith

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Mahaney

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Mrs. Carrie Owens

(Address) 206 N. Chase St.

Filed MAR 9 - 1927 HAMPSON JONES, M. D. Registrar

Per

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

about 1 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) no other history

(duration) yrs. mos. ds.

(Signed) D. T. Hennessy M. D.

(Coroner)

March 8, 1927 (Address) 2502 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem. Date of Burial 3/9 1927

UNDERTAKER Clarence D. Hensley ADDRESS 578 N. Bdwy

Spec.—1-10-21—M&T—1500 Bks.

E 19902

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19902

## CERTIFICATE OF DEATH.

REGISTERED NO. 57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Maryland General Hospital (ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Montgomery

(a) RESIDENCE NO. 13 Depot St Lewistown Pa. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F. | W | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 9-21-06

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs. or min. |
|---|---|---|---|---|
| | 20 | 5 | 17 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Lewistown (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER H B Montgomery

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Estella Musser

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Hospital Records (Address)

15 Filed 9-8 1927 19 P. M. C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8 1927

17 I HEREBY CERTIFY, That I attended deceased from March 8, 1927, to March 8, 1927, that I last saw her alive on March 8, 1927, and that death occurred, on the date stated above, at 9.04 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) ap proxima yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetic Coma

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno A Youngquist, M. D.

3/8, 19 27 (Address) Med Surgeon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lewistown Pa — DATE OF BURIAL Mar 9 1927

20 UNDERTAKER Harry W. Witzke — ADDRESS 1524 W. Lombard St.

Spec.—1-10-21—M&T—1500 Bks.

E 19903

E 19903

# HEALTH DEPARTMENT—CITY OF BALTIMORE

~~E 19758~~ Edmondson Ave Female Hosp 90 ~~E 19758~~

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Edmondson ave near North Bend Road ST. 26 WARD)

2-FULL NAME Esther S. Ray

(a) RESIDENCE NO. Edmondson ave near North Bend Road ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 87 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | white | widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. G. Ray

6 DATE OF BIRTH (month, day, and year) June 24. 1839

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 87 | 8 | 8 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER David Cross

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna.

12 MAIDEN NAME OF MOTHER Sarah Sharp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Sue Ray Griffith

(Address) Edmondson ave & North Bend

Filed 19 Registrar

MAR 29 - 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1926. to Mar. 1927.

that I last saw her alive on Mar 4. 1927.

and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

mitral regurgitation

(duration) one year yrs. mos ds.

CONTRIBUTORY (Secondary) Senility Cerebral Clot

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jas Ridpley M. D.

1927 (Address) 4500 Maple Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Mch 7. 1927

20 UNDERTAKER Chas O. Utterback — ADDRESS 1900 Eastern Place

Cor.—12-9-25—A Co.—200 Bks.

E 19904

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19904

## CERTIFICATE OF DEATH.

101-181

21-31

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 812 S. Eutaw St. St. _____ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wilhelmina Barnes, (C)

(a) RESIDENCE NO. 812 S. Eutaw St. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female. | Colored | Single. |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) January 22, 1926

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 1 | 1 | 18 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Charles King. (C)

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore, Md.

12 ~~MAIDEN~~ NAME OF MOTHER Mabel Barnes. (C)

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore, Md.

14 Informant Mabel Barnes. (C) mother

(Address) 812 S. Eutaw St.

15 Filed _____ 19____ C. HAMPSON JONES, M. D. Registrar

1927 per Ass't.

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7, 1927 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) Otto A. Reinhardt M. D.
(Coroner)

3/9, 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs..,.....mos.,.....ds. In the State .....yrs..,.....mos..,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 19

20 UNDERTAKER ADDRESS

Commissioner Health

UNIVERSITY OF MARYLAND MAR 9 1927

Spec. 12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19905

## CERTIFICATE OF DEATH.

31 E 19905

2-4

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

I-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals C.B.) St. Ward)

2-FULL NAME George Webis

(a) RESIDENCE NO. 806 S. Broadway St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1867

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 60 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town)

(State or country) Flordia

PARENTS

10 NAME OF FATHER John Webis

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed C. HAMPSON JONES, M. D. Registrar

1927 #1126

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from February 10 19 27, to March 7, 19 27,

that I last saw h... alive on March 7, 19 27,

and that death occurred, on the date stated above, at 8.45 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
Tracheotomy

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted Unknown

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. E. Gattens, M. D.

3-7-27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial MAR 9 19 1927

20 UNDERTAKER ADDRESS

Commissioner Health.

UNIVERSITY OF MARYLAND

By Wm. E. WORSAL

Spec.—1-12-23—M&T—500 Bks.

E 261 19906

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19906

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. JOHNS HOPKINS HOSPI ST. 25-779 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eileen Crumbliss

(a) RESIDENCE NO. 41 Cedar Ave. ST. Curtis Bay WARD Balto-Md

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1-14-23

7 AGE: 3 Years 4 Months 1 Days 25 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Noral Crumbliss

11 BIRTHPLACE OF FATHER (city or town) (State or country): Mo

12 MAIDEN NAME OF MOTHER: Mary Paletes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Record JOHNS HOPKINS HOSPI

15 - 1927 C. HAMPSON JONES, M. D. Registrar Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3-9 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 28, 1927, to Mar 9, 1927, that I last saw h alive on Mar. 9, 1927 and that death occurred, on the date stated above, at 7 50 a m

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Pertussis (duration) yrs. mos. 26 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Thomas W Cornwall M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem. DATE OF BURIAL: 3-10 1927

20 UNDERTAKER: Ed J. Hall ADDRESS: 1156 Hood Ave

Spec.—12-9-25—A Co.—200 Bks.

# 19907

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

74-001 E 19907

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 4907 Ferndale Ave. 28-64 Ward)

2-FULL NAME Ida Marie Connelly.

(a) RESIDENCE NO. 4907 Ferndale ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): widowed.

5a If married, widowed, or divorced (or) WIFE of: Andrew Connelly.

6 DATE OF BIRTH (month, day, and year): 5-13-1860.

7 AGE: Years 66 | Months 9 | Days 22. | IF LESS than 1 day.....hrs. or.....min. (24)

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md.

PARENTS

10 NAME OF FATHER: Isaac Jones

11 BIRTHPLACE OF FATHER (city or town): Baltimore

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Martha Townsend

13 BIRTHPLACE OF MOTHER (city or town): Baltimore

(State or country): Md.

14 Informant: Mrs Smith

(Address): 4907 Ferndale Ave.

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 7. 1927.

17

I HEREBY CERTIFY, That I attended deceased from March 1, 1927, to March 8, 1927, that I last saw her alive on March 7, 1927, and that death occurred, on the date stated above, at 10:58 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorhage.

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): Hypertension

(Duration) 10 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? physical signs + Blood

(Signed) Chester Kilam, M. D.

(Address) 2532 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — Date of Burial 3-12 1927

20 UNDERTAKER: Martin Fahey & Sons — ADDRESS 1927 North Ave

Spec—12-23-21—E.B.R.S.—400 Blks.

E 19908

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19908

## CERTIFICATE OF DEATH.

161-0

15-21

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1713 N. Fulton Ave St.....Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elmer Joseph Wineke Jr.

(a) Residence No. 1713 N. Fulton Ave. St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Lifetime mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Infant. Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6-DATE OF BIRTH (month, day and year) Mar. 7. 1927

7-AGE. ✓ yrs. ✓ mos. 1 ds.

If LESS than 1 day, ....hrs. or.... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town). (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Elmer Joseph Wineke

11-BIRTHPLACE OF FATHER (city or town). (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER. Phyllis Smith

13-BIRTHPLACE OF MOTHER (city or town). (State or Country) Hanover Pa. Deceased

14-

(Informant) Elmer Jos. Wineke

(Address) 1713 N. Fulton Ave

15-

Filed 1927

C. HAMPSON JONES, M. D. Registrar.

Per .....

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 8/27

17- I HEREBY CERTIFY, That I attended deceased from March 7 19 27 to March 8 19 27

that I last saw him alive on March 8 19 27,

and that death occurred, on the date stated above, at about 12 noon.

The CAUSE OF DEATH* was as follows:

Premature Birth.
(About 6 mo.)

(Duration) ... yrs ... mos ... ds

CONTRIBUTORY (Secondary) Insufficient Ammount

(Duration) ... yrs ... mos ... ds

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? No.

What test confirmed diagnosis? ✓

(Signed) George C. Shannon M. D.

3/9 1927 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

| 19-PLACE OF BURIAL, CREMATION OR REMOVAL. | DATE OF BURIAL. |
|---|---|
| St Peters | 3-7-27. 19 |
| 20-UNDERTAKER. | ADDRESS. |
| Martin Linsey Hood | 1827 W Baltimore |

Spec.—1-10-21—M&T—1500 Bks.

E 19909

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19909

## CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1550 Moreland Ave St. 15-68 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Chew Stewart

(a) RESIDENCE NO. 1550 Moreland Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of minnie Stewart

6 DATE OF BIRTH (month, day, and year) Feb. 13 1858

7 AGE 69 Years | Months No | 24 Days 22 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED Watchman

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Watchman

(c) Name of employer The American Brake Shoe & Foundry Co.

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER John T. Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Sarah A. Kennedy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Miss Sadie Stewart

(Address) 1550 Moreland Ave.

15 Filed Mar. 19 1927 Per C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 19 27.

17

I HEREBY CERTIFY, That I attended deceased from Feb. 15 1927 19 to March 7 1927 19,

that I last saw him alive on March 7 1927 19,

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of the Heart

(duration) X yrs. X mos. 18 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) One year yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Symptoms

(Signed) Charles E. Clark, M. D.

19 (Address) 3214 Piedmont Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge

DATE OF BURIAL March 9 1927

20 UNDERTAKER Richard F. Curley

ADDRESS 1808 N. Bway

Spec.—1-10-21—M&T—1500 Bks.

(Weigel)

# E 19910

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

11-28-27

E 19910

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1929 Ramsay ST. (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Weigel

(a) RESIDENCE NO. 1929 Ramsay ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late John Weigel.

6 DATE OF BIRTH (month, day, and year) Nov. 1, 1840

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 86 | 4 | 7 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) German

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Charlie Blanch (Address) 1929 Ramsay St

15 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 8 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb 1, 1927 to Mar 8, 1927, that I last saw h alive on Mar 8, 1927 and that death occurred, on the date stated above, at 6 4 m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Cellulitis (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) T. K. H. Campbell M. D.

Mar 8, 1927 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL Mar 10 1927

20 UNDERTAKER Harry H Metzler — ADDRESS 153 W Fayette St

THIS IS VERY IMPORTANT. SEE INSTRUCTIONS ON REVERSE SIDE.

Spec.—1-10-21—M&T—1500 Bks.

E 19911 HEALTH DEPARTMENT—CITY OF BALTIMORE E 19911

CERTIFICATE OF DEATH. 113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3 W. Hill St. ST. 27-31 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Driscoll

(a) RESIDENCE NO. 3 W. Hill St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 10 1926

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | | 2 | 29 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER George L. Driscoll

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Julia Ceres

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn

14 Informant Guy Will

(Address) 217 Mt Ave

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/9/27 19

17 I HEREBY CERTIFY, That I attended deceased from 3/8/27 19 . to 3/9/27 19 .

that I last saw him alive on 3/9/27 19 ,

and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Contributory tuberculosis)

(duration) History about week yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis

(duration) History "took cold" yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis? —

(Signed) Bernard J. Levy, M. D.

3/9/27 (Address) 910 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Frederick Md

DATE OF BURIAL 3/10/27 19

20 UNDERTAKER Harry H Nitzke

ADDRESS 534 W Lanvale

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE.

E 19912

## CERTIFICATE OF DEATH.

E 19912

1-PLACE OF DEATH

City of BALTIMORE: (No. 2 Elmwood Ave St., 27 Ward) REGISTERED NO. 27-43

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest M. Holland

(a) RESIDENCE NO. 2 Elmwood Ave. St. 27 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| M. | White | Married |

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~) Florence E. Holland

6 DATE OF BIRTH (month, day, and year) March 12, 1853

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 74 | 11 | 25 24 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant (Retired)

(b) General nature of industry, business, or establishment in which employed (or employer) Ans

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Nathan Holland

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Smith

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Florence E. Holland

(Address) 2 Elmwood ave.

15 1927 C. HAMPSON JONES, M. D.

Per ~~A.R.~~ Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/8/ 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1927, to March 8, 1927, that I last saw ~~him~~ alive on March 7, 1927, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Stomach (Pyloric)

(duration) 1 yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. L. Williamson, M. D.

3/8. 1927 (Address) Caseyburg, Balt, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury; and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Union Cemetery Rockville Md. Date of Burial March 10 1927

20 UNDERTAKER Wm C Black ADDRESS 927 N. Broadway

Spec—12-23-21—E.B.R.S.—400 Bks.

E 19913

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19913

## CERTIFICATE OF DEATH.

Registered No. 101

1-PLACE OF DEATH

City of BALTIMORE: (No. 1220 Belmont ave St., 9-46 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Sarah E. Shaw

(a) Residence No. 1220 Belmont ave St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) July 6 - 1862

7-AGE. 64 yrs. July mos. 8 ds. 2

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. none

(b) General nature of industry, business, or establishment in which employed (or employer). none

(c) Name of employer. —

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. William H Shaw

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER. Annie Kelly

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Carolina Co Md

14- (Informant). J. G. Waughtown

(Address) 1220 Belmont Avenue

15- Filed 1927 C. HAMPSON JONES, M. D. Registrar. Deputy

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 8 / 27

17- I HEREBY CERTIFY, That I attended deceased from March 6 1927 to March 8 1927

that I last saw her alive on March 8 1927,

and that death occurred, on the date stated above, at 9-30 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Influenza 2 wks ago

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Tom Lung

(Signed) Louis L. McCarron, M. D.

March 8, 1927 (Address) 416 E. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Green Mount Cem. | DATE OF BURIAL. March 11 1927

20-UNDERTAKER. Wm E Blacke | ADDRESS 927 N Broadway

Spec.—1-10-21 M&T 1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19914 E 19914

## CERTIFICATE OF DEATH

1-PLACE OF DEATH Balto City Hospitals

CITY OF BALTIMORE: (No.) Balto Md ST. 23-34 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph A. Price

(a) RESIDENCE NO. 31 E. Fontaine ST., ... WARD ...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ella Price

6 DATE OF BIRTH (month, day, and year): 1880

7 AGE: Years 46 Months Days If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Balto City Hosps Balto Md

15 Filed 3/9/1927 C. HAMPSON JONES, M. D. Registrar Per ...

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3-9 1927

17 I HEREBY CERTIFY, That I attended deceased from 3-3- , 1927 to 3-9- , 1927 that I last saw him alive on 3-8 , 1927 , and that death occurred, on the date stated above, at 8.20 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

(duration) yrs 7 mos 6 ds.

CONTRIBUTORY (Secondary) Involutional Melancholia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) Harry Goldman M. D.

(Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill

DATE OF BURIAL: Mar 12 1927

20 UNDERTAKER: Wm Cook

ADDRESS: 502 E North Ave

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19915

## CERTIFICATE OF DEATH.

101-91

E 19915

1-PLACE OF DEATH

City of BALTIMORE: (No. 614 S 14th St. 26-37 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leroy Earp

(a) RESIDENCE NO. 614 S 14th St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX ~~Male~~ M.

4 Color or Race W

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Agness M Earp

6 DATE OF BIRTH (month, day, and year) Jan 17 1893

7 AGE: Years 34 Months 1 Days 21 17 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron Moulder

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Standard Mfg Co

9 BIRTHPLACE (city or town)

(State or country) Pa.

PARENTS

10 NAME OF FATHER Archie Earp

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Pa.

12 MAIDEN NAME OF MOTHER Carrie Blumencamp

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Agness M Earp

(Address) 614 S 14th St

15 Filed ..... 19..... C. HAMPSON JONES, M. D. Registrar

Per .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8th 19 27

17 I HEREBY CERTIFY, That I attended deceased from Feb 28th 19 27, to March 8th, 19 27, that I last saw him alive on March 8th, 19 27 and that death occurred, on the date stated above, at 12 30 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 8 ds.

CONTRIBITORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Adam Tod, M. D.

, 19 (Address) 4700 Eastern ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — Date of Burial 3/11 1927

20 UNDERTAKER: W. E. Cook — ADDRESS 50 E North

1-1927 Perf

Spec.—12-9-25—A Co.—200 Bks.

E 19916

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

10 - E 19916

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2105 Herbert St., 15 68 Ward)

2-FULL NAME Emily Rebt Hammy

(a) RESIDENCE NO. 2105 Herbert St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. 1/2 mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | Wht | Singl |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) aug. 28 1922

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 4 | 6 | 11 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9 BIRTHPLACE (city or town) Butts

(State or country) Md.

PARENTS

10 NAME OF FATHER Wm. E Hamming

11 BIRTHPLACE OF FATHER (city or town) Reading

(State or country) Pa.

12 MAIDEN NAME OF MOTHER Hedy E. Mondas

13 BIRTHPLACE OF MOTHER (city or town) Butts Co

(State or country) Md.

14 Informant Mr Harry E. Hamming

(Address) 2105 Herbert St

15 Filed....., 19.....

R 9 - 1927

HAMPSON JONES M.D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept. 28 19 27, to Nov 9, 19 27, that I last saw h alive on Nov 8, 19 27, and that death occurred, on the date stated above, at 10 22 a.m.

The CAUSE OF DEATH* was as follows:

Post Hemorrhagic Anemia
Lung abscess & Empyema
Chronic

(duration) yrs. mos. 7 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Health Dept Lab.

(Signed) Edmund, M. D.

19, 19 (Address) 605 N Wolfe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Woodlawn M E Westerton Nov 13 1927

20 UNDERTAKER William Cook — ADDRESS 502 E North Ave

Spec.—1-12-23—M&T—500 Blks.

E 19917

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19917

## CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 877 N. Howard ST. 11-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gladys Se Fauta

(a) RESIDENCE NO. 877 N. Howard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND (or) ~~WIFE~~ of John Se Fauta

6 DATE OF BIRTH (month, day, and year) Feb 2-1896

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 31 | 1 | 7 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Isabel Bennett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER S. G. Bonny

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant John Se Fauta (Husband)

(Address)

15 Filed ..., 19... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-8-1927

17

I HEREBY CERTIFY, That I attended deceased from Sept. 10 —, 1926, to March 8, 1927,

that I last saw her alive on March 8 —, 1927,

and that death occurred, on the date stated above, at 10.30 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, Pulmonary

1

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Yes.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Sputum, X-Ray & Exam

(Signed) H. V. Tuttle M. D.

3-9, 1927 (Address) 1300 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park, Md. DATE OF BURIAL Mar 11 1927

20 UNDERTAKER C. H. Cook ADDRESS 502 E Monument

C. HAMPSON JONES M.D.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19918 E 19918

## CERTIFICATE OF DEATH

90

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1734 N. Bond St., 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elonzo R. Foard (Foard)

(a) RESIDENCE NO. 1734 N. Bond St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna C

6 DATE OF BIRTH (month, day, and year): May 5 1862

7 AGE: Years 64 Months 9 Days 21 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer): 060

(c) Name of employer: Bibb Slaughtering & Enameling Co

9 BIRTHPLACE (city or town)

(State or country): Md

PARENTS

10 NAME OF FATHER: Jesse S. Foard

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Cocander Foard

12 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md

14 Informant: Mrs. Anna C. Foard

(Address): 1734 N. Bond

15 Filed 1927 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: Mch 9 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 18, 1927, to Mch 9, 1927, that I last saw him alive on Mch 8, 1927, and that death occurred, on the data stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Mitral Valvular Heart disease

(duration) yrs. mos. 19 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Data of -

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Lucy Brashears, M. D.

3/9, 1927 (Address) 1823 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pulaski

Date of Burial: 3/11 1927

20 UNDERTAKER: H. C. Cook

ADDRESS: 570 E. Baltimore

Very important. See instructions on back of certificates.

MAR 1927 C. HAMPSON JONES M.D.

ORH

Spec.–7-17-26—A Co.—200 Bks.

E 19919

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

164 E 19919

REGISTERED NO. 1

1-PLACE OF DEATH

City of BALTIMORE: No. Charles & Cold Spring Lane (St.) 47-49 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabella Waddell

(a) RESIDENCE NO. Charles & Cold Spring Lane St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 9 1838

7 AGE: Years 88 Months 9 Days 10 — IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore County

PARENTS

10 NAME OF FATHER: Wm Waddell

11 BIRTHPLACE OF FATHER (City or town) (State or country): Baltimor County

12 MAIDEN NAME OF MOTHER: Hettie Vanston

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimor County

14 Informant: Sam'l E Crocker

(Address): Charles & Cold Spring Lane

15 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 8th 1927

17 I HEREBY CERTIFY, That I attended deceased from June, 1925, to March 8, 1927.

that I last saw h[illegible] alive on 3/7 1927

and that death occurred, on the date stated above, at 5 PM

The CAUSE OF DEATH* was as follows:

Senile Pneumonia

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Fracture right hip

(duration) 2 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Arthur J. Barrett, M. D.

19 (Address) 2008 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount

Date of Burial: 3/10 1927

20 UNDERTAKER: Wm Cook

ADDRESS: 502 E Nath

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 19920

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

× 101-E 19920

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 7-9 Ward)

2-FULL NAME Charles Newton Robertson

(a) RESIDENCE NO. Towson Rd Essex Md. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| male | white | single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 27/1917

| 7 AGE | Years | Months | Days | IF LESS than 1 day..... hrs. or.....min. |
|---|---|---|---|---|
| | 9 | 3 | 10 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) child

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Stanton Va. 3/9/27

PARENTS

10 NAME OF FATHER Charles Newton Rob

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Pearl Buchana

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Charles Newton Robertson

(Address) Essex Md

15 Filed C. HAMPSON JONES, M. D.

1927 By Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 8/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Prl Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Mason, M. D.

(Coroner)

(Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Mt Carmel Cem | 3/10/1927 |
| 20 UNDERTAKER | ADDRESS |
| John F. Connelly | Essex |

Very important. See instructions on back of

Spec.—12-9-25—A Co.—200 Rls.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19921

## CERTIFICATE OF DEATH.

179 E 19921

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1527 E 28th. St., 9-46 Ward)

2-FULL NAME Florence M Coulter

(a) RESIDENCE NO. 1527 E - 28th. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11-14

7 AGE: Years 52 | Months 2 | Days 3. | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Charles E Ford

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Maria Kennedy

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Baltimore Md

14 Informant _____

(Address) 1527 E 28th St.

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per _____

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8th 19 27

17 I HEREBY CERTIFY, That I attended deceased from March 5 19 27, to March 8, 19 27, that I last saw h er alive on Mar 8, 19 27, and that death occurred, on the date stated above, at 8 m.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Coma.

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter W White M.D.

3/9/27 (Address) 2800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cem — Date of Burial 3/11/ 19 27

20 UNDERTAKER: J. J. Foley Sons — ADDRESS 1318 Light

Very Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 1922

## CERTIFICATE OF DEATH.

3 | E 1922

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 919 N Gay ST. (WARD) 10-14

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Franklin Garrett

(a) RESIDENCE NO. 919 N. Gay ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed,~~ or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept. 15/1896

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 30 | 5 | 21 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Ice-dealer

(b) General nature of industry, business, or establishment in which employed (or employer): Ice business

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: William F. Garrett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Nora McAleer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): Mrs Nora Langhenan 919 N Gay St

15 Filed: APR 10 1927 By: H. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 8/1927

17

I HEREBY CERTIFY, That I attended deceased from Mar 1, 1927 to Mar 8, 1927.

that I last saw him alive on March 8, 1927.

and that death occurred, on the date stated above, at 6.45 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Camp Meade 1918

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) R. L. Coolidge, M. D.

, 19 (Address) 1514 E Balto St Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem — DATE OF BURIAL: March 11 1927

20 UNDERTAKER: Frank A. Fink — ADDRESS: 916 W Fay

Spec.—1-10-21—M&T—1500 Bks.

K Leisle

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19923

1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

74001

74 E 19923

REGISTERED NO.

CITY OF BALTIMORE: (No. N.W. Cor. Immaculate Conception 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ludovica Kleisle

(a) RESIDENCE NO. Augusta St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? 80 yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single. |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 2 1834

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 92 | 5 | 15 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Duties

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Michael Kleisle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Cunigunda Billinger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14

Informant (Address) Sister M. Dismas Notre Dame

15

Filed 10 1927 C. HAMPSON JONES, M. D. Registrar

By DK

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 9 1927

17

I HEREBY CERTIFY, That I attended deceased from April. 30 — 1923 to March. 9. 1927.

that I last saw her alive on March. 9. 1927.

and that death occurred, on the date stated above, at 12 45 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Hemorrhage Cerebral
hemiplegia.

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. J. Kurdy, M. D.

3/9/27 (Address) 110 E Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Notch Cliff Road, DATE OF BURIAL 3/12 1927

20 UNDERTAKER Frank A. Fink ADDRESS 916 N. Gay

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19924

## CERTIFICATE OF DEATH.

154-002

E 19924

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1170 W. Hamburg ST. 21-29 WARD)

2-FULL NAME Elmer Lee Griffith

(a) RESIDENCE NO. 1170 W Hamburg ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | — |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar 9. 1927

| 7 AGE | Years | Months | Days | If LESS than 1 day, 4 hrs. or 25 min. |
|---|---|---|---|---|
| | 0 | 0 | 0 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Emer Lee Griffith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Anna M Bruchey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Emer Lee Griffith

(Address) 1170 W. Hamburg St.

15 Filed MAR 10 1927, 19 C. HAMPSON JONES, M. D. Registrar

Per DK

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 9 1927

17

I HEREBY CERTIFY, That I attended deceased from Mar 9, 1927, to Mar. 9 1927.

that I last saw h alive on , 19 ,

and that death occurred, on the date stated above, at 8.50 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Valvular lesion of Heart

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Hann, M. D.

, 19 (Address) 1215 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dist Devel

DATE OF BURIAL: Mar 10 1927.

20 UNDERTAKER: Mr. & Mrs. John W Tregel & Son

ADDRESS: 836 W. Fayette St.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19925

## CERTIFICATE OF DEATH.

90 E 19925

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 4012 Church St (St.) (Ward) 13-5-2

2-FULL NAME Harriet A. C. Burkhart

(a) RESIDENCE NO. 4012 Church St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of: Frederick Burkhart

6 DATE OF BIRTH (month, day, and year): Oct 7, 1846

7 AGE — Years: 80 — Months: 5 4 — Days: 2 — If LESS than 1 day, ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Frederick Md

PARENTS

10 NAME OF FATHER: David Carlin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Frederick Md

12 MAIDEN NAME OF MOTHER: Sarah Willis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Harrisburg Pa

14 Informant (Address): Mrs F Coburn 4016 Church St.

15 Filed: 10 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 9 1927

17 I HEREBY CERTIFY, That I attended deceased from 1/6 1927, to Mar 9, 1927, that I last saw her alive on 3/9, 1927, and that death occurred, on the date stated above, at 4.10 a, m.

The CAUSE OF DEATH* was as follows:

Ch. arthritis deformans

(duration) 16 yrs. mos. ds.

CONTRIBUTORY (Secondary) Ch valv heart

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thos H [illegible] M. D.

3/9, 1927 (Address) 2020 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary's Frankford Pa DATE OF BURIAL: 11 1927

20 UNDERTAKER: D S Marshall ADDRESS: 3539 Fall Road

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19926

## CERTIFICATE OF DEATH.

X 101-001

REGISTERED NO. E 19926

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 212 W. Monument St. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucien W. Lisman Jr

(a) RESIDENCE NO. Catonsville Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred - yrs. 3 mos. ds. How long in U. S., if of foreign birth? ~~since birth~~ mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | widower |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth D

6 DATE OF BIRTH (month, day, and year) 04 28 1844

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| 82 | 7 years | 4 | 10 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Lucien W Lisman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bremen Germany

12 MAIDEN NAME OF MOTHER Frances L Donnell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Frances Donnell Lisman

(Address) Catonsville Maryland

15 Filed DEC 15 1927, 19 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3 - 9 1927

17

I HEREBY CERTIFY, That I attended deceased from 3 - 6, 1927, to 3 - 9, 1927,

that I last saw h·7 alive on 3 - 8, 1927

and that death occurred, on the date stated above, at 3.3 - A m

The CAUSE OF DEATH* was as follows:

LOBAR PNEUMONIA

(duration) - yrs. - mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John A. Donnell, M. D.

, 19 (Address) 112 E St. Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Green Mount Cem | Dec 19 1927 |
| 20 UNDERTAKER Henry H Burkert & Son | ADDRESS 1 E Lafayette Ave |

Spec.—8-24-14—M. & T.—2000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19927

## CERTIFICATE OF DEATH.

REGISTERED NO. E 19927

1-PLACE OF DEATH Greenspring Ave, 53 48

CITY OF BALTIMORE: (No. Children's Hospital School St. [illegible] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George E. H. Harper

(Residence in Baltimore: No. 8 Englewood Rd. Roland Park St.: 3 yrs., 2 mos. 8 ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

| 3-SEX. | 4-COLOR OR RACE. | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) |
|---|---|---|
| male | white | child |

6-DATE OF BIRTH. December 28, 1923 (Month) (Day) (Year)

7-AGE. 3 yrs. 2 mos. 8 10 ds. If LESS than 1 day, ....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... child (wd)
(b) General nature of industry, business, or establishment in which employed (or employer)..... "

9-BIRTHPLACE, (State or Country). Baltimore, Maryland

PARENTS.

10-NAME OF FATHER. Lawrence K. Harper

11-BIRTHPLACE OF FATHER (State or Country). Cleveland O.

12-MAIDEN NAME OF MOTHER Katherine Hardy

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dr. George E. Hardy

(Address) 518 Cathedral St.

15- Filed APR 10 1928, 191... J. HAMPTON JONES, M. D. Registrar. By ...

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. ~~December 8~~ March 8, 1927 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 7, 1927, to March 8 1927, that I saw h[illegible] alive on March 8 1927, and that death occurred, on the date stated above, at 3 30 P.m.

The CAUSE OF DEATH* was as follows:

Spinally ecl carcinoma of left humerus & pelvis

..... (Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pneumonia, lobular

..... (Duration) ..... yrs. 2 hrs mos. ..... ds.

(Signed) Harold K. Bohlman M. D.

March 8, 1927 (Address) Children's Hospital School

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 1 ds. In the State life yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Baltimore Md.

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Loudon Park Cem. DATE OF BURIAL. 3-10-1927

20-UNDERTAKER Henry W. Jenkins / Inslo ADDRESS Richard McCulloh

Spec.—12 9 25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19928

## CERTIFICATE OF DEATH.

129 E 19928

REGISTERED NO._____

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No._____ St. [redacted] 5-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Tony Peterson

(a) RESIDENCE NO. 1417 May St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored ~~White~~

5 Single, Married, Widowed, or Divorced, (write the word): ?

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1863

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 64 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James Peterson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary — ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant

(Address) Records

15 Filed_____ 19____ Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 1927

17

I HEREBY CERTIFY, That I attended deceased from December 15, 1926, to March 7, 1927, that I last saw h__ alive on March 6, 1927, and that death occurred, on the date stated above, at 4 30 m.

The CAUSE OF DEATH* was as follows:

Arterial Sclerosis

Chronic Myocarditis & Insufficiency

Chronic Interstitial Nephritis

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) ____ yrs. ____ mos. 6 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? general & Laboratory

(Signed) R Harper Gault, M. D.

7/16/69 19 27 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — Date of Burial: 3/10 19 27

20 UNDERTAKER: Edward Handley — ADDRESS 530 N Bdle

BALTIMORE CITY HOSPITALS

MAR 10 1927

HANDICAPPED

very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19929

1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

100-001

REGISTERED NO. E 19929

CITY OF BALTIMORE: (No. 5500 Garrison Blvd ST. 7-56 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Beloga

(a) RESIDENCE No. 5500 Garrison Blvd ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 8/ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | m | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1912

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 15 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Joe Beloga

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Emma Saltzbody

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Joe Beloga
(Address) 5500 Garrison Blvd

15 Filed MAR 10 1927 H. HA[illegible] JONES M[illegible]
Registrar

By [illegible]

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/10 1927

17

I HEREBY CERTIFY, That I attended deceased from March 5, 1926, to March 9, 1926, that I last saw her alive on March 9 1926 and that death occurred, on the date stated above, at 3 30 a m

The CAUSE OF DEATH* was as follows:

Bronchio Lobar pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) B. Kaden, M. D.

, 19 (Address) 2306 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Herschel Hebrew

DATE OF BURIAL 3/12 19 27

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E Balto St

Spec.—1-10-21—M&T—1500 Bks.

E 19930

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

33 E 19930
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1434 Orleans St. 5-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theodore Weed

(a) RESIDENCE NO. 1434 Orleans ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| M | C | Married |

5a If married, widowed, or divorced HUSBAND of Francis Weed

6 DATE OF BIRTH (month, day, and year) Oct 1, 1886

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 40 | 5 | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of Industry, business, or establishment in which employed (or employer) Chemical works

(c) Name of employer Griffin & Boyd.

9 BIRTHPLACE (city or town) (State or country) U. S. A. Md.

PARENTS

10 NAME OF FATHER Marcellus Weed

11 BIRTHPLACE OF FATHER (city or town) (State or country) U. S.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U S

14 Informant Francis Weed wife
(Address) 1434 Oslemont

15 Filed MAR 10 1927 Ref. R. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 31, 1927 to March 7 1927.

that I last saw him alive on March 6 1927.

and that death occurred, on the date stated above, at 9.05 P. m.

The CAUSE OF DEATH* was as follows:

Peritonitis

Entero-Colitis (duration) 5 wks over yrs. ds.

CONTRIBUTORY (Secondary) (duration) 5 wks yrs. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) R. J. Young M. D.

3/9 1927 Address 1429 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary DATE OF BURIAL March 10 1927

20 UNDERTAKER Mrs R a Elliott ADDRESS 1725 Ashland ave

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 19931 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100 E 19931

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1416 Harford Ave (St.) 9-18 (WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Anderson

(a) RESIDENCE NO. 1416 Harford Ave (St.)
(Usual place of abode)

WARD .....
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Col. | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah E. Anderson

6 DATE OF BIRTH (month, day, and year) 3-10-1837

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 89 | 11 | 27 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Easton Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Mrs Sarah E. Anderson
(Address) 1416 Harford Ave

15 Filed MAR 10 1927, 19 Per ..... Registrar

C. HARRISON JONES, M. D.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-7-1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 1, 1927, to March 6, 1927, that I last saw him alive on March 6, 1927, and that death occurred, on the date stated above, at 7 30 P. m.

The CAUSE OF DEATH* was as follows:
Acute Bronchial Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. L. Bornstein, M. D.

3-8, 1927 (Address) 733 Appleton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cem. — DATE OF BURIAL March 10 1927

20 UNDERTAKER Chas J. G. Locke — ADDRESS 1302 Jefferson

Spec.—6-9-19—H. P. Co.—1000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19932

## CERTIFICATE OF DEATH.

E 19932

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1905 N. Payson ST. 15-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jos. Leonard Helm

(a) RESIDENCE. No. 1905 N. Payson ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | White | Divorced |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 20, 1883.

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 43 | 3 | 17 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 066

(c) Name of employer Balto. News Co, Baltimore

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Joseph H. Helm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Louise Bailone

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant (Address) Mrs. Margaret Rahn (Sister) 15 Holb. ave, Govdn

15 Filed MAR 10 1927 16 [illegible] Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch. 7, 1927

17 I HEREBY CERTIFY, That I attended deceased from Mch. 2, 1927. to Mch. 7, 1927. that I last saw him alive on Mch. 7, 1927. and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Dementia Paecox -

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Asthenia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis Clinical Symptoms

(Signed) Wm. H. Tannebaker M. D.

. 19 (Address) 2740 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: 3/10/27

20 UNDERTAKER: Em. Hebel & Son

ADDRESS: 2503 Edmondson ave

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

162

**E 19933** CERTIFICATE OF DEATH. E 19933

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 15-58 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marian Rubens

(a) RESIDENCE NO. 2400 Eastern Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 3 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 15-1927

7 AGE — Years: — Months: 1 Days: 23 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto City

(State or country) Md

PARENTS

10 NAME OF FATHER Jacob Rubens

11 BIRTHPLACE OF FATHER (city or town) London

(State or country)

12 MAIDEN NAME OF MOTHER Ruth Weinberg

13 BIRTHPLACE OF MOTHER (city or town) Brooklyn

(State or country) N Y

14 Informant (Address) Jacob Rubens 2400 Eastern Ave

15 Filed MAR 10 1927 19 Issued 19 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Jan 5 19 26, to Jan 10 19 26, that I last saw him alive on Jan 10 19 26, and that death occurred, on the date stated above, at 2:30 A m.

The CAUSE OF DEATH* was as follows:

General Peritonitis

(Pneumococcus.)

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Injection of ambulance

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Jan 5, 1927

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) Wm Schluman, M. D.

3/10, 1927 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rodelheim Date of Burial 3/10 19 27

20 UNDERTAKER Jack Levin ADDRESS 1939 Eastern Ave

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

Garnett

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129 ✓

E 19934 DEATH

REGISTERED No. E 19934

City of BALTIMORE: (No. 517 N Eden St. 5-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Garnett

(a) RESIDENCE NO. 517 N. Eden St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: C

5 Single, Married, Widowed, or Divorced (write the word): ~~Widowed~~ Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Rachel Goldsborough

6 DATE OF BIRTH (month, day, and year): March 16 1901

7 AGE: Years 25 | Months 11 | Days 20 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country) Balto Md

PARENTS

10 NAME OF FATHER Julius Garnett

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Md

12 MAIDEN NAME OF MOTHER Martha Blackwell

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Md

14 Informant Martha Blackwell

(Address) 517 N. Eden St.

Filed APR 10 1927 HARRY W. JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1927, to March 7, 1927, that I last saw him alive on March 7, 1927, and that death occurred, on the date stated above, at 6 12 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) [illegible], M. D.

(Address) 508 Fremont St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery Date of Burial 4/10 1927

20 UNDERTAKER: Mrs Isabel H. Bailey ADDRESS 1115 Jefferson St.

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

Margaret Wolfe

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19935

## CERTIFICATE OF DEATH.

118-002

E 19935

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital 12-49 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs John Paul (Margaret) Wolfe

(a) RESIDENCE NO. Rogers Station Baltimore. ST. 2nd WARD
(Usual place of abode)

Length of residence in city or town where death occurred not known yrs. ds. How long in U. S., if of foreign birth? not known yrs. ds.
(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | white | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. John Paul Wolfe

6 DATE OF BIRTH (month, day, and year) unknown.

| 7 AGE Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|
| 68 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland ?

PARENTS

10 NAME OF FATHER John Sinnott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) not known

14 Informant Hospital Record
(Address)

15 FILED 1927, 19 HAMILTON JONES, M. D.
Per Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 8 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 7, 1927. to Mar 8, 1927.
that I last saw her alive on Mar 8, 1927.
and that death occurred, on the date stated above, at 9:05 A.M.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction
with Perforation & Gangrene

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) J. J. Sevoglaty, M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Cathedral Cem | 3/11 1927 |
| 20 UNDERTAKER George A. Talley | ADDRESS Fulton & Fayette |

Spec.—12-9-25—A Co.—200 Bks.

Gurak.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 19936

## CERTIFICATE OF DEATH.

E 19936

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 403 S Norris St. 19-28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Victoria Gurak

(a) RESIDENCE NO. 403 S Norris St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 17 1920

7 AGE: Years 7 Months 8 Days 21 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Baltimore

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore

PARENTS

10 NAME OF FATHER George Gurak

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Austria

12 MAIDEN NAME OF MOTHER Kate Pauch

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Austria

14 Informant Mrs. Gurak

(Address) 403 S Norris St

15 Filed MAR 10 1928 C. HAMPTON JONES, M. D. Registrar

by —

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/8/28

17 I HEREBY CERTIFY, That I attended deceased from 3/7/28, 19..., to 3/8/28, 19..., that I last saw her alive on 3/7/28, 19..., and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(History of Influenza)

(duration) ...yrs. 1 mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted —

If not at place of death? —

Did an operation precede death? ...Date of...

Was there an autopsy?

What test confirmed diagnosis? —

(Signed) Bernard J. Fenny, M. D.

3/9/1928 (Address) 910 W Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters — Date of Burial: March 1928

20 UNDERTAKER: John J. Fields — ADDRESS: 1200 W Fayette

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 19937

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19937

## CERTIFICATE OF DEATH.

REGISTERED NO. 74 of 1927

1-PLACE OF DEATH

City of BALTIMORE: (No. Old Town Bank Falls Ave & Bayard St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob Horch

(a) RESIDENCE NO. 537 N. Wolf St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 2 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | white | Wid |

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Anna M. Horch

6 DATE OF BIRTH (month, day, and year) June 30 1857.

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 69 | 2 | 8 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Watchman
(b) General nature of industry, business, or establishment in which employed (or employer) Old Town Bank
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Henry Horch

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Cath. ~~Bol~~ Roth

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Catherine Horch
(Address) 1311 Eager

15 Filed ..... 19..... C. HAMPSON JONES, M. D.
Registrar

R 10 1927 Per RH

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) March 8. 27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Cerebral hemorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) W. J. Peter

(duration) yrs. mos. ds.

(Signed) (Coroner) M. D.

, 1927 (Address) 1039 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery Date of Burial March 12, 1927

20 UNDERTAKER Henry Hoech, Son ADDRESS 130 E. Eager St.

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19938

## CERTIFICATE OF DEATH.

74-62

E 19938

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1416 N Callington ST.) 8-16 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George William Reilly

(a) RESIDENCE NO. 1416 N Callington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret Reilly

6 DATE OF BIRTH (month, day, and year): Sept 10, 1869

7 AGE — Years: 57 — Months: 5 — Days: 20 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Plumber

(b) General nature of industry, business, or establishment in which employed (or employer): Self

(c) Name of employer: Grasser

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Robert Reilly

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Virginia Meyers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Margaret Reilly wife

(Address): 1416 N Callington

15 Filed MAR 18 1927, 19 C. HAMPTON JONES, M. D. Registrar

Per KK

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 8 1927

17

I HEREBY CERTIFY, That I attended deceased from March 8, 1927, to March 8, 1927,

that I last saw h alive on March 8, 1927,

and that death occurred, on the date stated above, at 7.55 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 5d.

CONTRIBUTORY (Secondary): Hypertension

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Pressure

(Signed) Thos. E. E. Stevens, M. D.

3/19, 1927 (Address) 2872 Hartford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery

DATE OF BURIAL: March 12 1927

UNDERTAKER: Ebeneezer Hook Son

ADDRESS: 1501 E Eager

TION IS very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

99-004

E 19939

1-PLACE OF DEATH

## CERTIFICATE OF DEATH

REGISTERED NO. E 19939

City of BALTIMORE: (No. 929 N. Eden St. 10-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva Ruppert.

(a) RESIDENCE NO. 929 N. Eden St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. 9 mos. 13 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Late Frank A. Ruppert.

6 DATE OF BIRTH (month, day, and year) May 25 1865

7 AGE

| Years | Months | Days | IF LESS than 1 day hrs. or min.. |
|---|---|---|---|
| 61 | 9 | 13 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Henry Schaub

11 BIRTHPLACE OF FATHER (City or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Yoeckel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr Louis E. Ruppert.
(Address) 929 N. Eden St

15a Filed MAR 10 1927

19 G. HAMPSON JONES, M. D. Registrar

By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8 19 27

17 I HEREBY CERTIFY, That I attended deceased from Jan 23 19 27 to March 8 19 27

that I last saw h alive on March 8 19 27

and that death occurred, on the date stated above, at 4.20 P. m.

The CAUSE OF DEATH* was as follows:

Diffuse Bronchitis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. A. Stone M. D.

March 8 1927 (Address) 1507 E. Eager

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Holy Redeemer Cemetery | March 11 1927 |
| 20 UNDERTAKER | ADDRESS |
| Henry J. Koch Son | 1301 E. Eager St |

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001 ✓

E 19940

## CERTIFICATE OF DEATH.

REGISTERED NO. E 19940

1-PLACE OF DEATH Church Home & Infirmary

City of BALTIMORE: (No. Balt Md St. 15-61 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Leon

(a) RESIDENCE NO. 3620 Springdale Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. / mos. 2 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 8 - 1927

7 AGE — Years | Months | Days: 2 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Talbot Co Md

PARENTS

10 NAME OF FATHER Isidore Leon

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Rumania

12 MAIDEN NAME OF MOTHER Rebecca Kolant

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Rumania

14 Informant Isidore Leon

(Address) 3620 Springdale Ave

15 Filed MAR 10 1927 H. A. JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 — 1927

17 I HEREBY CERTIFY, That I attended deceased from 3-8 —, 1927, to 3-10, 1927,

that I last saw h.... alive on 3-10, 1927,

and that death occurred, on the date stated above, at 12 a m.

The CAUSE OF DEATH* was as follows:

Atelectasis

— (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Prematurity

— (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) J. H. McCracken, M. D.

, 19 (Address) Church Home & Inf. Balt.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery Date of Burial 3/10 1927

20 UNDERTAKER: Jack Levis ADDRESS 1439 E Balt St

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

199833

E 19941

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

45 E 19941

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. JOHNS HOPKINS HOS ST. 17-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm F. Coarey

(a) RESIDENCE NO. 753 Gough St. ST. Ally WARD Catonsville Pa.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ida M. Coarey

6 DATE OF BIRTH (month, day, and year): 1887

7 AGE — Years: 40 — Months: — Days: — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Latner 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): U-Can-

PARENTS

10 NAME OF FATHER: Nathaniel Coarey

11 BIRTHPLACE OF FATHER (city or town) (State or country): S-Can-

12 MAIDEN NAME OF MOTHER: Laura Hunt.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): S-Can-

14 Informant: Wards (Address) JOHNS HOPKINS HOS

15 Filed MAR 10 1927 19 Per C. HARRISON JONES, M.D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 17, 1927, to March 7, 1927, that I last saw him alive on March 7, 1927 and that death occurred, on the date stated above, at 11 30 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of rectum — metastases to liver, lungs, peritoneum & glands.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Myocardial failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) Milton Sheary, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Cem

DATE OF BURIAL: 3/10 27

20 UNDERTAKER: Samuel Hensley

ADDRESS: N Bolton

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19942

## CERTIFICATE OF DEATH.

129 E 19942

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 127 Mark Blvd ST. 21-29 WARD)

2-FULL NAME Mary Seboun

(a) RESIDENCE NO. 127 Mark Blvd ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | W. | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas J. Seboun.

6 DATE OF BIRTH (month, day, and year) Jan 10-1860

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 67 | 1 | 25 27 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto -

12 MAIDEN NAME OF MOTHER (?)

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs Leonard -

(Address) 127 Mark Blvd -

Filed MAR 10 1927 C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/7/27 19

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1925, to 3/7/27, 19

that I last saw alive on 3/7/27, 19

and that death occurred, on the date stated above, at 4.55 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac failure

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Chron Int. Nephritis

(duration) (?) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) [illegible], M. D.

3/8/27 (Address) 3755 Harford

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL 3/10/1927

20 UNDERTAKER Roger F. Gavan & Son. ADDRESS Gorsuch

Roger F. Gavan

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 19943

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 19943

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hebrew Aged Home ST. 5-8 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Cohen

(a) RESIDENCE No. 115 Aisquith street ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? 34 yrs mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| M | W | Widowed |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Minnie Cohen

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 85 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) old age

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Schofield

(Address) Jack Lewis Undertaker

15 Filed ..., 19 C. HAMPTON MOORE, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/10 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan, 1927, to Feb 10th, 1927, that I last saw her alive on Feb 9th, 1927, and that death occurred, on the date stated above, at 109 m

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs 6 mos ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Isaac L Wiener, M. D.

3/10, 1927 (Address) 30 S. 03 way

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Hebrew Rosedale | 3/10 1927 |

20 UNDERTAKER Jack Lewis 1439 E Baltimore ADDRESS

THIS IS VERY IMPORTANT—SEE INSTRUCTIONS ON REVERSE SIDE

Cert — 12-9-26 — A Co — 200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19944

E 19944

## CERTIFICATE OF DEATH.

1 PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St. 27-30 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jimmie Davis

(a) RESIDENCE NO. 521 Burgundy St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Col | single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1881

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 46 yrs | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md

PARENTS

10 NAME OF FATHER John Davis

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Hall

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Sarah Davis

(Address) 1113 Madison

15 Filed OCT 10 1927 C. HAMPSON JONES, M. D. Registrar

Per

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Oct 6 1927

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest

(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Central Hemorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. Edwards M. D.

(Coroner)

Oct 7 1927 (Address) 143 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem. Date of Burial 3 11 1927

20 UNDERTAKER Leon Hall ADDRESS 755 Druid

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

19945

Bass

# HEALTH DEPARTMENT—CITY OF BALTIMORE

11 E 19945

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 77 Preston ST. 17-24 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mildred Bass

(a) RESIDENCE NO. 77 Preston ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (Write the word) |
|---|---|---|
| F | C | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 7th 1925

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 1 | 9 | 1 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work child
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER James Bass

11 BIRTHPLACE OF FATHER (city or town)
(State or country) N. C.

12 MAIDEN NAME OF MOTHER Myrtle Lillie 3/9/27

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Myrtle Bass
(Address) 77 Preston St

Filed MAR 10 1927 C. CHAMPION JONES, M. D.
Per RR Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8th 1927

17 I HEREBY CERTIFY, That I attended deceased from March 1st 1927 to March 8th 1927
that I last saw her alive on March 8th 1927
and that death occurred, on the date stated above, at 11:30 A.M.
The CAUSE OF DEATH* was as follows:

Bronchopneumonia
Coma

(duration) yrs. mos 1 D ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis? Clinical
(Signed) H. Lee Ellis M. D.
(Address) 924 Mad. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Cemetery — DATE OF BURIAL 3/10 1927

20 UNDERTAKER Payne + Waters — ADDRESS 570 W. Preston

TION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

99-002

E 19946

## CERTIFICATE OF DEATH

E 19946

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1738 Bank St. 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie E. Jewer

(a) RESIDENCE NO. 1738 Bank St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 29, 1925

| 7 AGE | Years | Months | Days | If LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | | 8 | 9 | 10 |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER James W. Jewer

11 BIRTHPLACE OF FATHER (City or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Anna M. Yaeger

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant James W. Jewer (Address) 1738 Bank St

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

By RR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9 19 27

17 I HEREBY CERTIFY, That I attended deceased from Jan 5, 19 27, to March 9, 19 27.

that I last saw h[er] alive on March 8, 19 27

and that death occurred, on the data stated above, at 12 45 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis (Cause)

(duration) yrs. 2 mos. 1 4 ds.

CONTRIBUTORY (Secondary) Cardiac Dropsy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Data of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. C. Ryan M. D.

March 10 27 (Address) 1501 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery — Date of Burial Mar 11 19 27

20 UNDERTAKER Henry Sander & Sons Inc — ADDRESS 1710 Fleet St.

IF DEATH is plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 19947
1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

E 19947
REGISTERED NO.

CITY OF BALTIMORE; (No. 1305 N Chaffe st ST.: 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Johnson

(a) RESIDENCE. NO. 1305 N Chaffe st ST. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Female | Colored | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Baby

6 DATE OF BIRTH (month, day, and year) June 6 1923

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 3 | 9 | 3 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Delaus Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Sallie March

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mother Sallie March
(Address) 1305 N Chaffe st

15 Filed MAR 10 1927 C. HAMPSON JONES, M. D. Registrar
Per R.L.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 9 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 6, 1927, to Mar 8, 1927, that I last saw her alive on Mar 8, 1927, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia (acute)

(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Thos D Mulvey M. D.

3-9, 1927 (Address) 703 W Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Mount Calvary Cem | March 11 1927 |

20 UNDERTAKER Mrs R A Elliott ADDRESS 725 Ashland Av

THION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19948

## CERTIFICATE OF DEATH.

164 E 19948

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor St. 10-14 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Amelia Wilson

(a) RESIDENCE NO. Preston & Valley St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| F | B | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 29th 1846

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 80 81 | 7 | 8 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Samson Schiccoin

11 BIRTHPLACE OF FATHER (city or town) France

(State or country)

12 MAIDEN NAME OF MOTHER Sarah Wilkinson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country)

14 Informant Little Sisters of the Poor

(Address) Preston & Valley St.

Filed MAR 16 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 March 7th

17 I HEREBY CERTIFY, That I attended deceased from 3/6, 1927, to 3/7, 1927, that I last saw h[illegible] alive on 3/7, 1927, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D. McGlannahan, M. D.

3/7, 1927 (Address) 914 E. Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Laurel Cemetery 3/10/27

20 UNDERTAKER ADDRESS

Mrs. R. G. Elliott 1225 Ashland Ave

If DEATH in plain terms, so that it may be properly classified. Full statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

20592

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

101-E 101 19949

E 19949 DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE (No.) JOHNS HOPKINS HOSPITAL (St.) 8-17 (Ward)

2-FULL NAME Ralph Williams

(a) RESIDENCE No. 1607 St Josephs St (St.) (City) (Ward)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lenora

6 DATE OF BIRTH (month, day, and year) November 1884

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min |
|---|---|---|---|---|
| | 43 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Lewis Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Car

12 MAIDEN NAME OF MOTHER Rose Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Car

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed MAR 10 1927 H. HAMILTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 25 1927, to March 8 1927, that I last saw him alive on March 8 1927 and that death occurred, on the date stated above, at 9:50 P. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 19 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) E. Cowles Andrus, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Auburn — DATE OF BURIAL 3/10/27

20 UNDERTAKER Mrs. R. A. Elliott (ADDRESS) 1725 Eastland Ave

THIS IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec—12-23-21—E.B.R.S.—400 Eks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19950

## CERTIFICATE OF DEATH.

61-901 E 19950

1-PLACE OF DEATH

City of BALTIMORE: (No. 311 S. Stricker St. St. 14-28 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Hardy

(a) Residence No. 311 S. Stricker St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced, (Write the word.): single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): March 9, 1927

7-AGE: ...yrs. ...mos. ...ds. If LESS than 1 day, 5 hrs. or ...min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md.

PARENTS

10-NAME OF FATHER: August H. Hardy

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Baltimore Md.

12-MAIDEN NAME OF MOTHER: Lillian Schultz

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Baltimore Md.

14- (Informant): August H. Hardy

(Address): 311 S. Stricker St.

15- Filed ... 1927 C. HAMPSON JONES, M. D. Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): March 9 1927

17- I HEREBY CERTIFY, That I attended deceased from March 9, 1927 to March 9, 1927

that I last saw h... alive on March 9, 1927

and that death occurred, on the date stated above, at 3.15 P.M.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? 311 S. Stricker St.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) John G. Clemenburg M. D.

, 19 (Address) 1126 W. Cross St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: 3/10 1927

20-UNDERTAKER: James A Jones — ADDRESS: 720 East St

Instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19951

1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

129 ✓ 8-17

REGISTERED E 19951

City of BALTIMORE: (No. 1712 Lansing Avenue St. 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Baer

(a) RESIDENCE NO. 1712 Lansing Avenue St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? life yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary Baer

6 DATE OF BIRTH (month, day, and year) March 8, 1849

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 78 | 0 | 0 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wagon Builder

(b) General nature of industry, business, or establishment in which employed (or employer) 08 ✓

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Christopher Baer

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Baer

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs. Mary Baer

(Address) 1712 Lansing Avenue

15 Filed MAR 16 1927 C. HAMPSON JONES, M. D.

Per Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1927

17

I HEREBY CERTIFY, That I attended deceased from Mar 7 1927, to Mar 8, 1927, that I last saw h[illegible] alive on Mar 8 1927, and that death occurred, on the date stated above, at 1[illegible]38 m.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal Nephritis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted

If not at place of death!

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) John L. Davidson, M. D.

, 19 (Address) 1711 Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — Date of Burial 3/11/27

20 UNDERTAKER Albert L Hilt Jr — ADDRESS 1606 N. Chester St

OF DEATH in plain terms, so that it may be properly classified. FACT statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19952

## CERTIFICATE OF DEATH.

10-E 1952

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST. 16-37 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Meagher

(a) RESIDENCE No. 3809 Mt. Pleasant Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 3 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 20, 1925

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 1 | 3 | 18 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER William Meagher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Cath Wechselberger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs. Wm Meagher

(Address) 3809 Mt. Pleasant Ave

15 Filed MAR 10 1927, 19.. C. HAMPSON JONES, M. D. Registrar

Per K.K.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 10 1927

17

I HEREBY CERTIFY, That I attended deceased from March 8, 1927, to Mar 10, 1927, that I last saw him alive on March 10, 1927, and that death occurred, on the date stated above, at 7.30 a. m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Autopsied 3/8/27 Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Pos. K. L. Cult

(Signed) Myron S. Tull, M. D.

3/10, 1927 (Address) Sydenham Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Sacred Heart Cemetery | Mch 11 1927 |
| 20 UNDERTAKER | ADDRESS |
| Zurkler & Zurkler | 1731 E Eager St |

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 19953

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19953

## CERTIFICATE OF DEATH.

11-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 841 N. Patterson Pk Ave ST. 7-12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilhelmina Bocek

(a) RESIDENCE NO. 841 N. Patterson Pk Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? 38 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Bocek

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 65 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Czecho-Slovakia

PARENTS

10 NAME OF FATHER Joseph Kosak

11 BIRTHPLACE OF FATHER (city or town) (State or country) Czecho-Slovakia

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Frank Bocek

(Address) 812 N. Fulton Ave

15 Filed OCT 10 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 9 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar. 6, 1927, to Mar. 9, 1927,

that I last saw her alive on Mar. 9, 1927

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Pneumonia (Broncho

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) Vincent V. Cooke, M. D.

, 19 (Address) 845 N. Patterson Pk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Mar 12 1927

20 UNDERTAKER Hart Enoch Son — ADDRESS 1906 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly Classified. Exact statement of [illegible]

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 19954 HEALTH DEPARTMENT—CITY OF BALTIMORE E 19954

CERTIFICATE OF DEATH. 11-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 711 N Montford Ave ST., 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Sule

(a) RESIDENCE NO. 711 N Montford ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. 9 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) May 16 1908

| 7 AGE | Years | Months | Days 24 | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 18 | 9 | 18 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailoress

(b) General nature of industry, business, or establishment in which employed (or employer) Operator 080

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Frank Sule

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Josephine Sroula

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14

Informant Josephine Sule

(Address) 711 N Montford ave

15 FEB 1927 C. HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1927

17

I HEREBY CERTIFY, That I attended deceased from March 6. 1927. to March 8 1927

that I last saw h alive on March 8. 1927

and that death occurred, on the date stated above, at 730 A. M.

The CAUSE OF DEATH* was as follows:

Influenza—
Bronchial Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Finding

(Signed) Theodore Runckel M. D.

Mar 27, 1927 (Address) 606 N Dallas Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer DATE OF BURIAL March 11 1927

20 UNDERTAKER Frank Enochson ADDRESS 4066 Reisterstown Rd

INSTRUCTIONS on back of certificate. See instructions on back of certificate. TION is very important

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19955 ~~E 19955~~ 170

## CERTIFICATE OF DEATH.

E 19955

1-PLACE OF DEATH

City of BALTIMORE: (No. 806 St Paul St., 8-16 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Grant R. Chambers

(a) RESIDENCE NO. ~~1335~~ Patterson Pk. Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred about 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1848

7 AGE: Years: About 79 Months: Days: IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Milkman

(b) General nature of industry, business, or establishment in which employed (or employer): 678

(c) Name of employer

9 BIRTHPLACE (City or town): Balto.

(State or country)

PARENTS

10 NAME OF FATHER Thos. Chambers

11 BIRTHPLACE OF FATHER (city or town): ?

(State or country) Md.

12 MAIDEN NAME OF MOTHER M. E. Widdows

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Pa.

14 Informant: Mrs. Hogan

(Address) 133 Valley

15 Filed ..... 19..... C. HAMPSON JONES, M. D.

Per ..... Registrar

### CORONER'S CERTIFICATE OF Homicide

16 DATE OF DEATH (month, day, and year) March 8 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Injuries by bullets & hot water in brain

(duration) Instant yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) [illegible] M. D.

(Coroner)

March 8, 1927 (Address) 1639 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery. Date of Burial March 10 1927

20 UNDERTAKER: Grant - J. Ruth ADDRESS 1735 Harford Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

Johnson

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19956

161-901

E 19956

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. University Hospital St. 4-25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Johnson

(a) RESIDENCE NO. 745 W mulberry St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: blacks.

5 Single, Married, Widowed, or Divorced. (write the word): infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 7, 1927.

7 AGE: Years Months 24 Days 21

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): md

PARENTS

10 NAME OF FATHER Lester Johnson

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Jamaica

12 MAIDEN NAME OF MOTHER Bertha Dyson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore

14 Informant

(Address)

15 Filed OCT 10 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 March 1

17 I HEREBY CERTIFY, That I attended deceased from Mar. 1, 1927, to Mar. 1, 1927, that I last saw her alive on Mar 1, 1927, and that death occurred, on the data stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage Disease of newborn

Edema not noted

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Premature birth

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Elizabeth Sherman M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

UNIVERSITY OF MARYLAND

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUP very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 19957

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19957

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Joseph's Hospital

CITY OF BALTIMORE: (No. Caroline & Oliver ST., WARD) 16 N-42

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pearl Gravity (Mrs.)

(a) RESIDENCE No. 55 Baltimore ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3/8/27

7 AGE — Years | Months | Days | If LESS than 1 day, 2 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St Josephs Hosp. Baltimore Md.

PARENTS

10 NAME OF FATHER James L Gravity

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Stella Wagick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant
(Address) JOHNS HOPKINS HOSPITAL

15 10 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/6/27 1927

17 I HEREBY CERTIFY, That I attended deceased from 3/6/27, 1927 to 3/6/27, 1927 that I last saw h— alive on 3/6/27, 1927 and that death occurred, on the date stated above, at 11:45 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) — yrs. mos — ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. A. McCardell, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

20 UNDERTAKER

DATE OF BURIAL 19

ADDRESS

MAR 10 1927

Commissioner Health

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 19958

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19958

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Josephs Hospital

CITY OF BALTIMORE: (No. Caroline & Aliceria ST. 76-42 WARD)

REGISTERED NO. 161-406

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Crowley (nurse)

(a) RESIDENCE No. 55 Baltic Ave Raspeburg md. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 3/8/27

7 AGE: Years | Months | Days | If LESS than 1 day, 2 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St Josephs Hosp. Baltimore Maryland

PARENTS

10 NAME OF FATHER James L. Crowley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Stella Wojcik

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant

(Address)

15 Filed MAR 10 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/8/27 1927

17

I HEREBY CERTIFY, That I attended deceased from 3/8/27, 1927, to 3/8/27, 1927, that I last saw her alive on 3/8/27, 1927, and that death occurred, on the date stated above, at 10:45A m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. A. Kelly M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS MAR 10 1927

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19959

## CERTIFICATE OF DEATH.

E 19959

1-PLACE OF DEATH St Joseph Hospital

CITY OF BALTIMORE: (No. Caroline & Alisa ST. 10-14 WARD)

REGISTERED NO. 161-801

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Paul Weigel

(a) RESIDENCE No. 5 19. Harford Rd ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 3/6/27

7 AGE — Years | Months | Days | If LESS than 1 day 3 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) St Joseph's Hospital

PARENTS

10 NAME OF FATHER Joseph George Weigel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore md.

12 MAIDEN NAME OF MOTHER Annie F Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant

(Address)

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-6-27 1927

17 I HEREBY CERTIFY, That I attended deceased from 3/6/27, 1927 to 3/6/27, 1927

that I last saw h/ alive on 3/6/27, 1927

and that death occurred, on the date stated above, at 7.15 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H A. McCann, M. D.

19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL MAR 10 1927

20 UNDERTAKER Commissioner Health.

ADDRESS

TION is very important. See instructions on back of certificates.

MAR 10 1927

Par. Dr. E. Woodall

Spec.-7-17-26—A Co.—200 Bks.

E 19960

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19960

## CERTIFICATE OF DEATH

161-001

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1111 Forest St. 10-15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Foetus Griffith

(a) RESIDENCE NO. 1111 Forest St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Foetus

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 3/7/27

7 AGE Years Months Days IF LESS than 1 day hrs. 40 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto, Md.

(State or country)

PARENTS

10 NAME OF FATHER Wm. J. Griffith

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Mary B. Goos

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto, Md.

14 Informant Mary B. Goos

(Address) 1111 Forest St

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

March 7, 1927

17 I HEREBY CERTIFY, That I attended deceased from March 7, 1927 to March 7, 1927

that I last saw her alive on March 7, 1927

and that death occurred, on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Prematurity (5½ mos.)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. H. Thomas, M. D.

19 (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial 19

20 UNDERTAKER

ADDRESS

MAR 10 1927

JOHNS HOPKINS HOSPITAL

Commissioner of Health.

Per Wm. S. [illegible]

MAR 10 1927

C. HAMPSON JONES, M. D.

Registrar

Per RPM

1135

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# E 19961

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

# E 19961

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 5501 York Road, St. 27-48 Ward)

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME John M. Schaut.

(a) RESIDENCE: (No. 5501 York Road, St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white.

5 Single, Married, Widowed, or Divorced, (write the word): widower

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Catherine Cochen Schaut,

6 DATE OF BIRTH (month, day, and year) May 31st 1842

7 AGE: Years 84 85 Months 9 Days 17

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) 080

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Jacob Schaut

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Elizabeth Smith

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany.

14 Informant Mrs Frances E Schaut.

(Address) 5501 York Road

15 Date Filed 1927 C. HAMPSON JONES, M. D.

Per Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8, 1927

17 I HEREBY CERTIFY, That I attended deceased from March 1 1927, to March 8 1927, that I last saw h[illegible] alive on March 7 1927, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) [illegible], M. D.

March 8, 1927 (Address) 5501 Glenwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral Cem. Date of Burial March 11, 1927

20 UNDERTAKER Geo. E. Pearce & Son

ADDRESS 90 W. Saratoga St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19962

## CERTIFICATE OF DEATH

46 E 19962

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1921 W. North Ave Ward) 15-24

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Eckenwalter

(a) RESIDENCE NO. 1921 W. North Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) February 14 1860

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 67 | 25 | 23 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) North Carolina

(State or country)

PARENTS

10 NAME OF FATHER Anton Eckenwalter

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Lauer

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mae W. Stearns

(Address) 1921 W. North Ave

15 Filed MAR 9 1927 C. HAMPSON JONES, M. D. Registrar

Per RRH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/9/27 19

17 I HEREBY CERTIFY, That I attended deceased from Jan 1-27, 19 to Mch 9/27, 19

that I last saw h[illegible] alive on 3/9/27, 19

and that death occurred, on the date stated above, at 11-58 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma Breast

Complicating Intestinal Obst.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

, 19 (Address) 1921 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — Date of Burial Mar 12 1927

20 UNDERTAKER George J. Smith — ADDRESS 1532 Fallsway

TION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12 9 25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-002

E 19963

## CERTIFICATE OF DEATH.

E 19963

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Aged Mens Home St. 4-27 Ward)

2-FULL NAME David Worley

(a) RESIDENCE NO. 1400 W. Lexington St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Wid.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct. 4 1837

7 AGE: 89 Years: 9o Months: 5 Days: 6 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Merchant
(b) General nature of Indnstry, business, or establishment in which employed (or employer): 04
(c) Name of employer

9 BIRTHPLACE (city or town): York Pa
(State or country)

PARENTS

10 NAME OF FATHER: Isaac Worley

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Pa

12 MAIDEN NAME OF MOTHER: Kate Shilups

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Pa

14 Informant: M. E Forrest
(Address): Macon

15 10 1927 C. HAMPSON JONES, M. D.
Registrar

Per Beef

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 10 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 3 27, to Feb 10, 27, that I last saw h..... alive on Feb 7, 27, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Senile Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary): Prostate Adenoma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? Date of No

Was there an autopsy?

What test confirmed diagnosis?

Feb 10 27, M. D.

, 19 (Address) 939 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loraine — Date of Burial: Mar 1 1927

20 UNDERTAKER: George J Smith — ADDRESS 1532 Hollins

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# E 19964 HEALTH DEPARTMENT—CITY OF BALTIMORE E 19964

## CERTIFICATE OF DEATH.

161

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Vincent's Infant Asy Sta. 10-14 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Connelly

(a) RESIDENCE NO. 1015 Hillman ST., ..... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | Infant |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) 3/10/27

| 7 AGE | Years | Months | Days | If LESS than ~~1 day~~, / hrs. or ~~min.~~ |
|---|---|---|---|---|
| Infant | | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Child

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER James Connelly

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Anna Lewis

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Sister Catherine President
(Address) St. Vincent's Inf. Asy. Balto. Md

15 FILED OCT 10 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/10/1927

17

I HEREBY CERTIFY, That I attended deceased from 3/10/1927 to 3/10/1927, that I last saw him alive on 3/10/1927, and that death occurred, on the date stated above, at 1:45 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity 28 wks.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Not known

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) [illegible] M. D.

3-10-1927 (Address) 12 York St. Sanford

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Holy Redeemer | 3-10-27 |
| 20 UNDERTAKER | ADDRESS |
| Martin Fahey Sons | 1937 W North Ave. |

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 19965

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19965

## CERTIFICATE OF DEATH.

101-0

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4335 Harford Avenue ST. 27-44 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augusta Serelda Elliott

(a) RESIDENCE NO. 4335 Harford Avenue ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph C. Elliott

6 DATE OF BIRTH (month, day, and year) Nov. 27, 1881

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 45 | 3 | 11 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Maryland

PARENTS

10 NAME OF FATHER Emil Heinericks

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country) Unknown

14 Informant Joseph C. Elliott
(Address) 4335 Harford Ave.

10 1927 C. HAMPSON JONES, M. D. Registrar

BY

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 8, 1927

17 I HEREBY CERTIFY, That I attended deceased from March 7, 1927, to March 8, 1927, that I last saw her alive on March 7, 1927, and that death occurred, on the date stated above, at 5 A.M. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (Left).

(duration) yrs. mos 1 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed djagnosis? Physical Signs —

(Signed) Howard F. Hummel M. D.

, 19 (Address) 722 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Trinity Cemetery | Mar. 11, 1927. |
| 20 UNDERTAKER | ADDRESS |
| Frederick Lassahn & Son | Fullerton, Md. |

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 19966

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 19966

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Hopkins Hospital St. 7-9 Ward)

2-FULL NAME Rosetta Ryan

(a) RESIDENCE NO. 17 Melrose Ave Catonsville Md Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | col | single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXX X

6 DATE OF BIRTH (month, day, and year) Oct 13/1926

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | | 4 | 24 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Thomas Ryan

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Dora Bradby

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Thomas Ryan

(Address) Catonsville Md

15 Mar 1927 C. HAMPSON JONES, M. D. Registrar

Per. RCH

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 10-27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tetany

(Autopstat Hospital)

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Rickets

(duration) .....yrs. .....mos. .....ds.

(Signed) J. H. Weiss M. D.

(Coroner)

3/10/27 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Star Cem Date of Burial Mar 12 1927

20 UNDERTAKER Easton Bros ADDRESS Edmondson City

Mon should be carefully supplied. AGE should be given in YEARS, MONTHS and DAYS. PHYSICIANS should write DISEASES CAUSING DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 19967

90 E 19967

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1033 William St. 2433 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter W. Tilton.

(a) RESIDENCE NO. 1033 William St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. 7 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male. | White. | Single. |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March, 3, 1919.

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min.. |
|---|---|---|---|---|
| | 8, | | 7. | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy. ptd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore. Md.

(State or country)

PARENTS

10 NAME OF FATHER William G. Tilton.

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Va.

12 MAIDEN NAME OF MOTHER Lena Carneal.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va.

14 Informant Mrs. Lena Tilton, (Mother).

(Address) 1033 William Street.

15 1927 C. HAMPSON JONES, M. D.

Per Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10/27

17 I HEREBY CERTIFY, That I attended deceased from Dec 13/26 19..., to March 10/27 19...

that I last saw he alive on March 10/27 19...

and that death occurred, on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) ...yrs. 3 mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm. D. Holloway M. D.

March 10/27 (Address) 1 W Mt Vernon Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Cedar Hill Cem. Date of Burial March 12 1927

20 UNDERTAKER E. Howard Evans ADDRESS 38 E Fort Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

R 1 0 1927

Spec.—12-9-25—A Co.—200 Bks.

E 19968

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19968

## CERTIFICATE OF DEATH.

43

1-PLACE OF DEATH

City of BALTIMORE: (No. 1249 W. Cross, St. 21-29 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James J Larkin.

(a) RESIDENCE NO. 1249 W Cross. St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced (or) WIFE of: Mary W. O'Keefe

6 DATE OF BIRTH (month, day and year): June 8 1860

7 AGE: Years 66. Months____ Days 2 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer): dry

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Patrick Larkin

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Cecelia Kennedy

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Ireland

14 Informant Mrs Mary W O'Keefe

(Address) 1249 W Cross St

15 Filed_____ 19____ C. HAMPSON JONES, M. D.

Per_____ Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1927

17

I HEREBY CERTIFY, That I attended deceased from January 5, 1927, to March 10, 1927, that I last saw h.. alive on March 10, 1927, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Embolism: due to carcinoma of mouth and glands. about 2 yrs.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Is Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) E. A. Kitlowski, M. D.

(Address) 421 S Ellwood Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem. Date of Burial 3 14 1927

20 UNDERTAKER: James J. Curran & Son ADDRESS 701 Hollins St

Per J. J. Curran

MAR 11 1927

Don should be carefully supplied. AGE should be given in YEARS, MONTHS and DAYS. If LESS than 1 day, hours or minutes. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19969

## CERTIFICATE OF DEATH.

101-00 E 19969

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 936 W Lombard St. 14-29 Ward)

2-FULL NAME Edward Dolan

(a) RESIDENCE NO. 936 W Lombard St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | Sing'l |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 24 1892

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 34 | 10 | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Telephone Helper

(b) General nature of industry, business, or establishment in which employed (or employer) Bell Tel Co

(c) Name of employer

9 BIRTHPLACE (city or town) Balt

(State or country)

PARENTS

10 NAME OF FATHER Peter Dolan

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Burke

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Mrs Mary Burke

(Address) 936 W Lombard St

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/5 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Chas. F. Wagner M. D.
(Coroner)

, 19 27 (Address) 323 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem Date of Burial Nov 11 1927

20 UNDERTAKER John F. Cowan & Son ADDRESS

Per F. J. Cowan 700 Hollins St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state ... OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA... very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19970

101-001 E 19970

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 202 Albemarle St. 3-5 Ward)

2-FULL NAME Robert H. Gerber

(a) RESIDENCE NO. 202 Albemarle St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Feb 11 1926

| 7 AGE | Years | Months | Days | IF LESS than 1 day..... hrs. or.....min. |
|---|---|---|---|---|
| | 1 | | 28 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Henry Gerber

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Pa

12 MAIDEN NAME OF MOTHER Emma Bucher

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Pa

14 Informant Henry Gerber

(Address) 202 Albemarle St.

C. HAMPSON JONES, M. D.

Filed ..... 19 .....

Per ..... Registrar

MAY 1927

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest

(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M. Hamilton, M. D.

(Coroner)

May 16, 1927 (Address) 700 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Homydale Date of Burial May 11 1927.

20 UNDERTAKER ADDRESS

W. M. Cook 502 E Madison

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 19971

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19971

## CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4011 Woodbine Ave (ST.) 29-64 (WARD)

2-FULL NAME Josephine Spoor

(a) RESIDENCE (No.) 4011 Woodbine Ave (ST.) (WARD)

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Isaac Spoor

6 DATE OF BIRTH (month, day, and year): Mar 7 1843

7 AGE

| Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|
| 84 | 0 | 2 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of Industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): New York

PARENTS

10 NAME OF FATHER: Deldeah Hanes

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. Y.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. Y.

14 Informant: Marcia J. Gantman

(Address) 4011 Woodbine Ave

15 Filed: MAR 10 1927 Per

C. HARRISON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 9 1927

17 I HEREBY CERTIFY, That I attended deceased from March 9, 1927, to March 9, 1927, that I last saw h[illegible] alive on March 9, 1927, and that death occurred, on the date stated above, at 3:45 p. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Cause.)

Not known (duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) M. H. Buttenwieser, M. D.

3/9, 1927 (Address) 3110 Reisterstown Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Leo Moines, Iowa

DATE OF BURIAL: Mch 11 1927

20 UNDERTAKER: W. H. Cook

ADDRESS: 502 E Madison

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# E 19972 HEALTH DEPARTMENT—CITY OF BALTIMORE E 19972

## CERTIFICATE OF DEATH.

21

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2238 Mura. ST. 8-12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William J. Lutts

(a) RESIDENCE No. 2238 Mura. ST. ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed, or Divorced~~, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs. S. Lutts

6 DATE OF BIRTH (month, day, and year): July 21, 1873

7 AGE: Years 53 | Months 7 | Days 10 | If LESS than 1 day, hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lather. 040

(b) General nature of industry, business, or establishment in which employed (or employer): Plumber

(c) Name of employer: Francis Haigley

9 BIRTHPLACE (city or town) (State or country): Balt.

PARENTS

10 NAME OF FATHER: John J. Lutts.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balt

12 MAIDEN NAME OF MOTHER: Anna Mat.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balt.

14 Informant: William J Lutts

(Address) 2238 Mura st

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 9 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 28, 1927, to Mar 9, 1927.

that I last saw h alive on Mar 9, 1927

and that death occurred, on the date stated above, at 10 15 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac & Respiratory Paralysis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Diffuse Nephritis

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Frederick E. Hamer, M. D.

Mar. 19 27 (Address) 301 N Pat Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rudeman Cemty

DATE OF BURIAL: March 11 1927

20 UNDERTAKER: George J. Ruth

ADDRESS: 735 Harford ave

1 0 1927 C. HAMPSON JONES, M. D.

Registrar

By RCH

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 19973

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

× 90E 19973

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1302 W Lanvale St. 16-23 Ward) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Burrell

(a) RESIDENCE No. 1302 W Lanvale St., Ward Virginia

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 35 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Robert Burrell

6 DATE OF BIRTH (month, day, and year) — — 1857

7 AGE

| Years | Months | Days | If LESS than 1 day, hrs. or ... min. |
|---|---|---|---|
| 70 | 7 | 9 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Urbanna Va

PARENTS

10 NAME OF FATHER John Lockley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mollie Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mollie Jones

(Address) 1302 W Lanvale St

15 Filed MAR 11 1927 19 Per

C. HAMPSON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8 1927

17 I HEREBY CERTIFY, That I attended deceased from March 4. 1927 to March 8. 1927. that I last saw her alive on March 8. 1927. and that death occurred, on the date stated above, at 2.45 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

& Arteriosclerosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. S. Howell M. D.

3/10 1927 (Address) 1191 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Leakin's Wharf Va. DATE OF BURIAL 3/12 1927

20 UNDERTAKER Chris. N. Johnson ADDRESS 416 N. Caroline St.

mation should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. If less than one day, state hours or minutes. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19974

## CERTIFICATE OF DEATH.

46

E 19974

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 636 W. Lee St. (WARD) 27-30

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Kelley Carter

(a) RESIDENCE NO. (Usual place of abode) 636 W. Lee St. WARD

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louis C. Carter

6 DATE OF BIRTH (month, day, and year): [illegible] 1869

7 AGE: Years 58; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Burnell Budick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Sarah Justis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant (Address): Louis C. Carter 636 W. Lee St.

15 Filed MAR 11 1920 HAMILTON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 8 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 18, 1926, to Mar 8, 1927.

that I last saw her alive on Mar 7, 1927.

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteri

(duration) 1 yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. V. Cannon, M. D.

3/7, 19 27 (Address) 805 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL 3-11 19 27

UNDERTAKER: John H. Tradwin — ADDRESS 1027 Round Hill

mation should be carefully supplied. AGE should be stated EXACTLY. If infant, NEWBORN child, STILLBORN, or DIED BEFORE BIRTH, so state. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

106-001

E 19975

## CERTIFICATE OF DEATH

E 19975

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1209 Park ave St. 11-21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude Hudson

(a) RESIDENCE NO. 1209 Park ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Col | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Riley Hudson

6 DATE OF BIRTH (month, day, and year) 1890

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min.. |
|---|---|---|---|---|
| | 37 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wife — 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Calvert Co

(State or country) Maryland —

PARENTS

10 NAME OF FATHER John Patterson

11 BIRTHPLACE OF FATHER (City or town) Calvert Co

(State or country) Maryland —

12 MAIDEN NAME OF MOTHER Annie Hooks

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co

(State or country) Maryland.

14 Informant Dempsey Patterson

(Address) 604 Lime st

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D.

MAR 1 1927 Per ..... Registrar

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL RECORD. Any erasure, alteration or illegible entry will cause delay. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/9 1927

17 I HEREBY CERTIFY, That I attended deceased from 3/4, 1927, to 3/9, 1927, that I last saw her alive on 3/9, 1927, and that death occurred, on the date stated above, at 10:20 P. m.

The CAUSE OF DEATH* was as follows:

acute Lobar Pneumonia

(duration) — yrs. — mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Dan Drumheller M. D.

3/10, 1927 (Address) 124 W Lee st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Brooks. Calvert Co Md — Date of Burial 3-18-27

20 UNDERTAKER John H. Trader — ADDRESS 1027 Hanover Street

Spec.—12-9-25—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

100-001

E 19976

REGISTERED E 19976

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St., 15-59 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bennett S. Littauer

(a) RESIDENCE NO. 2336 Reisterstown Rd. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lillie Littauer

6 DATE OF BIRTH (month, day, and year): July 14 1863

7 AGE: Years 64 | Months :- | Days 28 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED.

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Richmond

(State or country): Va.

PARENTS

10 NAME OF FATHER: Solomon Littauer

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Ann Brown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Germany

14 Informant: Mrs. Julian Littauer

(Address) 2336 Reisterstown Rd

15 Filed MAR 11 1927, 19

C. HAMPSON JONES, M. D. Registrar

By R.K.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3-9-27 19

17 I HEREBY CERTIFY, That I attended deceased from 3-9, 1927, to 3-9, 1927, that I last saw h[illegible] alive on 3-9, 1927, and that death occurred, on the date stated above, at 4:30 A m.

The CAUSE OF DEATH* was as follows:

Cardiac failure

(duration) yrs. mos. 1 day

CONTRIBUTORY (Secondary): Broncho pneumonia.

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Moses Greenfield, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Hebrew Cem. Date of Burial: 3/11/1927.

20 UNDERTAKER: Harris Sondheim ADDRESS 118-20 W Mt Royal Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAR 11 1927

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19977

## CERTIFICATE OF DEATH.

100 E 19977

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) James Andrew Whiting (St.) 11-24 (WARD)

2-FULL NAME 1008 McCulloh

(a) RESIDENCE NO. 1008 McCulloh ST., ..... WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 10 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: child

6 DATE OF BIRTH (month, day, and year): January 1926.

7 AGE — Years: — Months: 10 — Days: — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ~~child~~

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Child

9 BIRTHPLACE (city or town) (State or country): Richmond, Va.

PARENTS

10 NAME OF FATHER: James E. Whiting

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Lucille Ellington

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Lucille Whiting (Address) 1008 McCulloh

15 Filed MAR 7 1927. C. HAMPSON GIBBS, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mch 9 1927

17 I HEREBY CERTIFY, That I attended deceased from Mch 7, 1927, to Mch 9, 1927, that I last saw h~~im~~ alive on Mch 9, 1927, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Bronco Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Acute Bronchitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Samuel A Bam, M. D.

, 1927 (Address) 937 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Ave — DATE OF BURIAL: March 11 1927

20 UNDERTAKER: Daniel Easton — ADDRESS: Penna Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19978

## CERTIFICATE OF DEATH.

100-001
100 E 19978

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 514 Union Ave St. 13-57 Ward)

2-FULL NAME Mary Jane Phillips

(a) RESIDENCE NO. 1 514 Union Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: David Phillips

6 DATE OF BIRTH (month, day, and year): Nov. 28-1848

7 AGE — Years: 78 — Months: 3 — Days: 8/10 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Co. Md.

PARENTS

10 NAME OF FATHER John M. Smith

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary J. T——

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Mrs. Minnie Rogers

(Address) 514 Union Ave. City

15 Filed MAR 11 1927, 19

C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb. 27, 1927, to Mch. 8, 1927, that I last saw h...tive on Mch. 8, 1927, and that death occurred, on the date stated above, at 12 50 A. M.

The CAUSE OF DEATH* was as follows: Pulmonary Oedema

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? same

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Observation

Signed Wm. F. Kelly M. D.

8, 19 27 (Address) 4 Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Mary's Camden Date of Burial: March 11 1927.

20 UNDERTAKER: Horace F. Burgee ADDRESS: 363 Falls Road

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 19979

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 E 19979

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1628 E. Baltimore St. 69 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Rudman

(a) RESIDENCE NO. 1628 E. Baltimore St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? 2 yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | white | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Rudman

6 DATE OF BIRTH (month, day, and year) 1865

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 62 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Lectures & Congregation

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Hyman S. Rudman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sarah Rudman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Sarah Rudman (Address) 1628 E. Balt St

15 Filed MAR 1 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/10 1927

17 I HEREBY CERTIFY, That I attended deceased from 1-15, 1927, to 3-10, 1927, that I last saw h— alive on 3-8, 1927 and that death occurred, on the date stated above, at 9 a m

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.
Disease Interstitial Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Reuel Parker M. D.

, 19— (Address) 3325 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Levering Cemetery

DATE OF BURIAL 3-11 1927

20 UNDERTAKER Jack Levin 1409 Eutaw

ADDRESS

INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE should be stated in YEARS, MONTHS and DAYS. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19980

## CERTIFICATE OF DEATH.

90 E 19980

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 607 N. Central av ST. 5-8 WARD)

2-FULL NAME George Brooks

(a) RESIDENCE NO. 607 N. Central av ST., WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown.

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or min. |
|---|---|---|---|---|
| | 43 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balti Md

PARENTS

10 NAME OF FATHER Morris Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balti Md

12 MAIDEN NAME OF MOTHER Mary Diggs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Rosa Brown
(Address) 607 N. Central av

15 Filed MAR 11 1927 19 C. HAMPTON JONES, M. D. Registrar
Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 10 1927

17

I HEREBY CERTIFY, That I attended deceased from Mar 5, 1927, to Mar 9, 1927, that I last saw him alive on Mar 9, 1927 and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows: Chronic Nephritis heart disease

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 3-12 mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robt. L. Green, M. D.

3-10, 1927 (Address) 120 Aisquith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: asbury cemetery — DATE OF BURIAL: mch 13 1927

UNDERTAKER: Edward Bryan — ADDRESS: 1691 orleans St

N. B.—INFORMANT, WHETHER RELATIVE OR NOT, should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19981

## CERTIFICATE OF DEATH

100-001

REGISTERED NO. E 19981

1-PLACE OF DEATH

City of BALTIMORE: (No. 602 E. Madison 10-15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Melvin Harries

(a) RESIDENCE NO. 602 E. Madison St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 8 mos. 3 ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colord

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 19. 1925

7 AGE — Years: 1 — Months: 8 — Days: 19 — IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Md. (State or country)

PARENTS

10 NAME OF FATHER Lafayette Harris

11 BIRTHPLACE OF FATHER (City or town) (State or country) Memphis Tenn

12 MAIDEN NAME OF MOTHER Louise Royal

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Louise Harris (Address) 602 E. madison St.

15 Filed MAR 1 1927 — 16 C. HAMPSON JONES M.D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/8 1927

17 I HEREBY CERTIFY, That I attended deceased from March 3, 19 27 to March 8, 19 27

that I last saw h[illegible] alive on March 8, 19 27.

and that death occurred, on the data stated above, at 10 20 P. m.

The CAUSE OF DEATH* was as follows:

Lobular Pneumonia

(duration) 11 days

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted ✓

If not at place of death?

Did an operation precede death? no Data of

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) J. N. Stateler M. D.

3/27 1927 (Address) 1111 Pa Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: asbury cem. [illegible] — Date of Burial: march 1 1927

20 UNDERTAKER: Edward Bryan — ADDRESS 1631 orleans st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

# E 19982 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

42-33 90 E 19982

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 16 E. Henrietta ST. ..... WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth S. Tull

(a) RESIDENCE NO. 16 E. Henrietta ST., ..... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Winfield S. Tull

6 DATE OF BIRTH (month, day, and year) Oct. 4, 1847

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 79 | 5 | 5 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Wm. Charnock (Address) 16 E. Henrietta St.

15 Filed ..... 19 ..... HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 9 1927

17

I HEREBY CERTIFY, That I attended deceased from March 5, 1927, to Mar 9, 1927, that I last saw her alive on March 8, 1927, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Lawson Wilkins, M. D.

Mar 10, 1927 (Address) 1014 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery — DATE OF BURIAL Mar 12 1927

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

mation should be carefully supplied. AGE should be stated EXACTLY. Ditto marks should not be used. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 19983

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

101-001

E 19983

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Maryland General Hospital 27-56

CITY OF BALTIMORE: (No. ..... ST., ..... WARD)

2-FULL NAME Charles L. Cook

(a) RESIDENCE NO. 128 W. Virginia Ave. ST., ..... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 41 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Mary E. Cook

6 DATE OF BIRTH (month, day, and year) Nov. 20, 1885

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs. or ....min. |
|---|---|---|---|---|
| | 41 | 4 | 19 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Newspaper Carrier 8-6

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto, Md.
(State or country)

PARENTS

10 NAME OF FATHER Wm. F. Cook

11 BIRTHPLACE OF FATHER (city or town) Augusta,
(State or country) Maine

12 MAIDEN NAME OF MOTHER Annie E. Martin

13 BIRTHPLACE OF MOTHER (city or town) Balto, Md.
(State or country)

14 Informant Hospital Record
(Address)

15 Filed MAR 11 1927, 19 ... C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1927

17

I HEREBY CERTIFY, That I attended deceased from March 3, 1927, to March 4, 1927, that I last saw h.. alive on March 4, 1927, and that death occurred, on the date stated above, at 1:20 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema ? hr.

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of ...

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Jno. A. Hampton Jones, M. D.

, 19 (Address) 1 W. Mt. Vernon Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL MAR 12 1927, 19

20 UNDERTAKER Geo. H. Little — ADDRESS 2700 Pennsylvania Ave

E—WRITE PLAINLY, with pen and ink. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See Instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# E 19984 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

20-27 31 E 19984

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1820 Penrose Ave., ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miriam M. Woods

(a) RESIDENCE NO. 1820 Penrose Ave., ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced (or) WIFE of John C. Woods.

6 DATE OF BIRTH (month, day, and year) Apr. 14, 1887

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 39 | 10 | 22 25 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John G. W. Bartscher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Catherine Tomlinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto., Md.

14 Informant John C. Woods

(Address) 1820 Penrose Ave.,

15 Filed MAR 1 1927, 19 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March, 9, 1927

17

I HEREBY CERTIFY, That I attended deceased from Dec. 14th/26 19 to March 7, 19 27,

that I last saw her alive on March 7, 19 27

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac collapse

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ean V. Cronkhite, M. D.

3/10, 1927 (Address) 24 N. Fulton Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| London Park Cem. | Mch. 11 1927 |
| UNDERTAKER | ADDRESS |
| Wm. E. Black | 927 N. Broadway |

mation should be carefully supplied. AGE should be stated EXACTLY. Information CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 19985

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19985

## CERTIFICATE OF DEATH.

100-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mt. Hope Retreat St. 2863 WARD)

2-FULL NAME John Henry Treat

(a) RESIDENCE NO. Mt Hope Retreat ST., 27th WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. (c) How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mch 1861

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 66 | 0 | Unknown | |

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Formerly Clerk

(b) General nature of Industry, business, or establishment in which employed (or employer) Grocer

(c) Name of employer Unemployed

009

9 BIRTHPLACE (city or town) (State or country) N.Y.

PARENTS

10 NAME OF FATHER Geo W Treat

11 BIRTHPLACE OF FATHER (city or town) New Milford (State or country) Conn.

12 MAIDEN NAME OF MOTHER Catharine Hitt

13 BIRTHPLACE OF MOTHER (city or town) Somerstown (State or country) N.Y.

14 Informant Mrs F. F. Coder

(Address) 303 - 7th Ave. Belair Apts

15 Filed MAR 1 1927 19 G. HAMILTON JONES, M.D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept 1, 1926, to Mch 10, 1927,

that I last saw him alive on Mch 4, 1927,

and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) Senile Dementia

(duration) 3 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) C. B. Conn, M. D.

3. 10 1927 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Woodlawn Park | March 11 1927 |
| 20 UNDERTAKER John C. Mitchell | ADDRESS 1900 Eutaw Place |

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19986

## CERTIFICATE OF DEATH.

E 19986

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 236 N. Fulton ave ST.) 20-27 45 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eugenia A. Richardson

(a) RESIDENCE NO. 236 N. Fulton ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Francis M Richardson

6 DATE OF BIRTH (month, day, and year): Dec 10 1858

7 AGE: Years 68 Months 3 Days 1 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Alexander Fourille

11 BIRTHPLACE OF FATHER (city or town) (State or country): France

12 MAIDEN NAME OF MOTHER: Eugenia Frazine

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Francis M. Richardson

(Address) 236 N. Fulton Ave

15 Filed MAR 11 1927

C. HARRISON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mch 10 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1927, to Mch 10, 1927.

That I last saw h[illegible] alive on Mch 9, 1927.

and that death occurred, on the date stated above, at 10 A.M. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Sigmoid Colon

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? yes Date of Jan 10 1927

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Frank J Thurston M. D.

3/10, 1927 (Address) 2702 Hartford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park DATE OF BURIAL: Mch 12 1927

20 UNDERTAKER: John O. Mitchell ADDRESS: 1900 Eutaw Pl

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19987

## CERTIFICATE OF DEATH.

E 19987

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1633 Division ST., 14-20 WARD)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walt O. Rawlings

(a) RESIDENCE NO. 1633 Division ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: Colored
5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 23d. 57

7 AGE: Years | Months | Days 16 | If LESS than 1 day, hrs. or min.
17

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of Industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William G. Rawlings

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Alice Pratt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant William G. Rawlings
(Address) 1693 Division St

15 Filed MAR 1 1927 C. HAMPSON JONES, M. D. Registrar
By K K

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28 1927

17 I HEREBY CERTIFY, That I attended deceased from March 24, 1927, to March 28, 1927, that I last saw h alive on March 24, 1927, and that death occurred, on the date stated above, at 7 30 P. m.

The CAUSE OF DEATH* was as follows:

Uremia Nephritis - Chronic

(duration) 1 yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Pyemia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) H. Lee Clein, M. D.

(Address) 922 Monroe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery — DATE OF BURIAL: 3/11/1927

20 UNDERTAKER: Wm. Geo. E. Holland — ADDRESS: 1681 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

19988

# HEALTH DEPARTMENT—CITY OF BALTIMORE

181-004

E 10088

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Sq Hospital St. 3-27

2-FULL NAME Agnes Seymour

(a) RESIDENCE NO. 1620 W. Balto St Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 27 1926

7 AGE: Years — Months 4 — Days 11/3 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Balto —

PARENTS

10 NAME OF FATHER: Robt Seymour

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Md

12 MAIDEN NAME OF MOTHER: Madelina Alberta

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Balto Md

14 Informant (Address): Robt Seymour 1620 W. Balto St

15 Filed MAR 11 1927 Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3-10 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, (or) autopsy or inquiry.) thereon and from the evidence obtained [illegible] inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suffocation from Smoke (Duration) 15 hrs.

CONTRIBUTORY (Secondary) Clothes on, mash boiler Caught on fire (Duration) yrs. mos. ds.

(Signed) Thos. L. Horton M. D. (Coroner)

mch 11th 1927 (Address) Curtis Bay.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

Balto Md

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross a a Co — Date of Burial 3-11 1927

20 UNDERTAKER: C H Harlan — ADDRESS 115 E Fayette St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

11-001

E 19989

## CERTIFICATE OF DEATH.

E 19989

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 129 E Cross St. (Ward) 24-33

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME — Anna C. Gleason

(a) RESIDENCE. NO. 129 E Cross St., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Feb 15 - 26

7 AGE — Years: 1 — Months: — Days: 22 24 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: /

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Mason Ville Md.

PARENTS

10 NAME OF FATHER: Thomas Jr Gleason

11 BIRTHPLACE OF FATHER (city or town) (State or country): Fairfield Ky.

12 MAIDEN NAME OF MOTHER: May Cross

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Peru

14 Informant (Address): Thomas Gleason 129 E Cross St

15 Filed MAR 11 1927 E. HAMPTON JONES, M. D. Registrar

per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/9 1927

17 I HEREBY CERTIFY, That I attended deceased from March 4 1927, to March 9 1927, that I last saw h[illegible] alive on March 8 1927, and that death occurred, on the date stated above, at 2.15 A.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary): Influenza

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C Mitchell M. D.

3/9 1927 (Address) 1299 Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cemetery Nov. 11 27

DATE OF BURIAL

20 UNDERTAKER: George E. Johnson Co.

ADDRESS: 1101 Park Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 19990

E 19990

## CERTIFICATE OF DEATH.

101-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1605 Walker ST., 19 WARD)

2-FULL NAME Harrison Parks

(a) RESIDENCE NO. 1605 Walker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | Col | Married |

5a If married, widowed, or divorced HUSBAND of ~~or) WIFE of~~ Mary Parks.

6 DATE OF BIRTH (month, day, and year) July 24 1901

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 26 | 7 | 15 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Labor

(c) Name of employer O'Donnell

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Parks.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Annie Nicholas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary Parks.

(Address) 1605 Walker

15 Filed ..., 19 ...

Per ... Registrar

C. HARRISON [illegible], M. D.

MAR 1 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-9- 1927

17 I HEREBY CERTIFY, That I attended deceased from 3-1- 1927 to 3-9- 1927, that I last saw him alive on 3-9- 1927, and that death occurred, on the date stated above, at 8.45 P.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature] M. D.

3-9- 1927 (Address) 611 N. Carey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem.

DATE OF BURIAL 3/3 1927

20 UNDERTAKER Byron Wright

ADDRESS 218 N. Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19991

## CERTIFICATE OF DEATH.

74001

74 E 19991

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3799 Juniper Road ST. 12-49 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Rhodes

(a) RESIDENCE NO. 3799 Juniper Road ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. 5 mos. 28 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

N. B.—WRITE PLAINLY, WITH PENCIL OR INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Oliver L. Rhodes

6 DATE OF BIRTH (month, day, and year) Sept. 12, 1849

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 77 | 5 | 28 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER James E. Cochran

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Jane Magarity

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant E. Oliver Rhodes
(Address) 3799 Juniper Road

15 Filed MAR 11 1927, 19 [illegible] JONES, M. D.
Registrar

Per [illegible]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 10 1927

17 I HEREBY CERTIFY, That I attended deceased from 3-7, 1927, to 3-9, 1927, that I last saw h[illegible] alive on 3-9, 1927, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage.

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Cardio Renal [illegible] Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

3/10, 1927 (Address) 2806 Garrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL 3/11 19 27

20 UNDERTAKER Century Co. Mears

ADDRESS [illegible] Pulaski

Spec.—12-9-25—A Co.—200 Bks.

19992

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 19992

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home & Infirmary Broadways Fairmount Ward)

2-FULL NAME Mrs. Marian Skinner

(a) RESIDENCE NO. Church Home & Infirmary Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James W. Skinner

6 DATE OF BIRTH (month, day, and year) March 8th 1847

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 80 | — | 1 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Kent Co. Md

PARENTS

10 NAME OF FATHER Wm D. Stephens

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Cecil Co. Md

12 MAIDEN NAME OF MOTHER Gamble

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Kent Co. Md

14 Informant Estella Constable

(Address) 2116 Calvert St Balto Md

Filed MAR 11 1927 H. M. S. M. D.

Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

March 9 - 1927

17 I HEREBY CERTIFY, That I attended deceased from March 3, 1927, to March 9, 1927, that I last saw h.W alive on March 9, 1927, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Myocardial failure Hypocardio-arterio sclerosis (duration) 7 yrs. mos. ds.

18 Where was disease contracted (if not at place of death) At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Maxwell T. Tolbert M. D.

, 19 (Address) Church Home - City

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

St Pauls Cemetery Kent Co. Md 3/12 1927

20 UNDERTAKER — ADDRESS

Hughes & Jones Inc 117 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 19993

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

100-001 E 19993

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1716 Carlisle Place ST. 8-17 WARD)

2-FULL NAME Ambrose Kane

(a) RESIDENCE NO. 1716 Carlisle Place ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | C | |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 8, 1926

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | | 8 | 1 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md.

PARENTS

10 NAME OF FATHER Phillip Kane

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Nellie Curtis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Phillip Kane (father) (Address) (1716 Carlisle Place)

15 Filed ....., 19 ..... Registrar

MAR 11 1927 CHARLES JONES, M. D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9 1927

17 I HEREBY CERTIFY, That I attended deceased from March 6 1927 to March 9 1927.

that I last saw h alive on March 8 1927,

and that death occurred, on the date stated above, at 3 30 p.m.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia (Primary)

(duration) yrs. 1 mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R D Young, M. D.

3/9, 1927 (Address) 1729 Monument st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Calvary Cem

DATE OF BURIAL March 11 27

20 UNDERTAKER Mrs R A Elliott

ADDRESS 1725 Oakland

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. -7-17-26—A Co.—200 Bks.

E 19994

99-001

E 19994

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. 24-33

City of BALTIMORE: (No. 136 E Gittings St. ____ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ann Elizabeth Toole

(a) RESIDENCE NO. 136 E Gittings St. ____ Ward ____

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. ____ mos. ____ ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? ____ yrs. ____ mos. ____ ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Wid

5a If married, widowed or divorced HUSBAND of (or) WIFE of: John Toole

6 DATE OF BIRTH (month, day, and year): Sept 19 — 1844

7 AGE — Years: 82 — Months: 5 — Days: 21 — IF LESS than 1 day ____ hrs. or ____ min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work

(b) General nature of industry, business, or establishment in which employed (or employer): ____

(c) Name of employer: home

027

9 BIRTHPLACE (city or town) ____ (State or country): Md

PARENTS

10 NAME OF FATHER: John Walker

11 BIRTHPLACE OF FATHER (City or town) ____ (State or country): Md

12 MAIDEN NAME OF MOTHER: /

13 BIRTHPLACE OF MOTHER (city or town) ____ (State or country): Md

14 Informant: A. E. Toole

(Address): 136 E Gittings

15 Filed MAR 1 1927, 19 ____ Per ____ HAMPSON JONES M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 10 19 27

17 I HEREBY CERTIFY, That I attended deceased from Mar 8, 19 27, to Mar 10, 19 27,

that I last saw h[illegible] alive on Mar 8, 19 27,

and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows: Bronchitis

(duration) ____ yrs. ____ mos. 3 ds.

CONTRIBUTORY (Secondary): old age

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of ____

Was there an autopsy? no

What test confirmed diagnosis? ____

(Signed) J. M. Taylor, M. D.

3/10, 19 27 (Address) 1319 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill — Date of Burial: 3/14 19 27

20 UNDERTAKER: H. W. Cook — ADDRESS: 502 North Ave

E 19995 (Rec. 1500 Blks.)

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 19995

1-PLACE OF DEATH Maryland General Hospital — REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Evan Larmore

(a) RESIDENCE NO. Bivalve Md — ST., ..... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 10 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M. | White | Married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of E. A. Larmore

6 DATE OF BIRTH (month, day, and year) May 22 1880

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| 46 | 47 | 9 | 16 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wicomico Co Maryland

PARENTS

10 NAME OF FATHER Evan Larmore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bivalve Maryland

12 MAIDEN NAME OF MOTHER Larmore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bivalve Md.

14 Informant (Address) Wife. E A Larmore. Bivalve Md

15 Filed MAR 1 1927 HAMPTON JONES, M. D. Registrar

Per [illegible]

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 10 1927

17

I HEREBY CERTIFY, That I attended deceased from 2/10/27, 19 ..., to 3/10/27, 19 ...,

that I last saw him alive on 3/10/27 —, 19 ...,

and that death occurred, on the date stated above, at 2 15 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Tumor

No Autopsy possible.

(duration) Unknown yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Incurred in the service

(duration) 2 yrs. 2 mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes. Date of 2/16/27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno D Somerville M. D.

. 19 (Address) Salisbury Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Salisbury Md | Mar 12 27 |
| 20 UNDERTAKER | ADDRESS |
| Geo M. Smith & Son | Salisbury Md |

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19996

## CERTIFICATE OF DEATH.

14-20 74-001

E 19996

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 221 E. North Ave. St. ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Joseph McCaffrey

(a) Residence No. Hotel Altamont St., ..... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 5 mos. 10 ds. How long in U. S., if of foreign birth? 70 yrs. 5 mos. 10 ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Wells

6-DATE OF BIRTH (month, day and year) Sept 30-1856

7-AGE. 70 yrs. 5 mos. 10 ds. If LESS than 1 day, ....hrs. or....min.

8-OCCUPATION OF DECEASED:
(a) Trade, profession, or particular kind of work..... Insurance adjuster
(b) General nature of industry, business, or establishment in which employed (or employer)..... Investigating
(c) Name of employer..... Insurance adjustment Bur.

9-BIRTHPLACE (city or town)..... Baltimore
(State or Country)..... Maryland

PARENTS.

10-NAME OF FATHER, George McCaffrey

11-BIRTHPLACE OF FATHER (city or town)..... Unknown
(State or Country)..... Unknown

12-MAIDEN NAME OF MOTHER, Margaret (?)

13-BIRTHPLACE OF MOTHER (city or town)..... Unknown
(State or Country)..... Unknown

14-
(Informant)..... Mrs John G Price (friend)
(Address)..... 7 Beechdale Road

15-
Filed..... 19?? ..... Registrar.

MAR 11 1927

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 10 1927

17- I HEREBY CERTIFY, That I attended deceased from March 9 1927 to March 10 1927

that I last saw h.. alive on March 9 1927

and that death occurred, on the date stated above, at 3.15 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration)..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 5 yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Paralysis. B. Pneumo

(Signed) Daniel K Rawlet M. D

19 (Address) 1405 Eutaw Pl.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cemetery — DATE OF BURIAL. March 12 1927

20-UNDERTAKER, STEWART & MOWEN COMPANY — ADDRESS 102 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every answer should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19997

## CERTIFICATE OF DEATH.

REGISTERED NO. E 19997

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 501 Woodlawn Rd ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest Ames Robbins

(a) RESIDENCE NO. 501 Woodlawn Rd ST., 26 WARD Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 6 mos. 8 ds. How long in U. S., if of foreign birth? 72 yrs. 6 mos. 8 ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emily S. Robbins

6 DATE OF BIRTH (month, day, and year): Sept-2-1854

7 AGE

| Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|
| 72 | 6 | 8 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Horace H. Robbins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Whitesfield Conn.

12 MAIDEN NAME OF MOTHER: Mary Hyde

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N.Y. City N.Y.

14 Informant: Mr. E.G. Robbins Jr. (Son)
(Address): 501 Woodlawn Rd.

15 Filed MAR 1 1927 HARRY JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 10 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb-11, 1927, to Mar-10, 1927, that I last saw h[illegible] alive on Mar-10, 1927, and that death occurred, on the date stated above, at 6-10a. m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis 6 days
Myocarditis Acute

(duration) ... yrs. ... mos. 27 ds.

CONTRIBUTORY (Secondary) Chronic Arteriosclerosis Senile (duration) 2+ yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical sign no

(Signed) M. Gibson Forster, M. D.

3/11/1927 (Address) 422 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Mar 12 27

20 UNDERTAKER: Stewart & Mosser Co — ADDRESS: 108 W North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT R[ecord]. mation should be carefully supplied. AGE should be stated EXACTLY CAUSE OF DEATH in plain terms, so that it may be properly classified. EX[amples]. TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH E 19998 — REGISTERED NO. E 19998 — 179

CITY OF BALTIMORE: (No.) Mt Hope Retreat (ST.) 28-63 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Winifred Wagner.

(a) RESIDENCE NO. Mt Hope Retreat ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ——— yrs. ——— mos. ——— ds. How long in U. S., if of foreign birth? ——— yrs. ——— mos. ——— ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown.

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 62 | Unknown | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Patrick Purcell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Winifred Joyce

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mt Hope Friends (Address) Mt Hope Retreat.

15 Filed MAR 11 1927 19 C. HAMPSON JONES, M. D. Per ——— Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr 1 1925 to March 7 1927, that I last saw her alive on March 7 1927, and that death occurred, on the date stated above, at 10.55 A m.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

Arteria Sclerosis

(duration) Unknown. yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Chronic Mania

(duration) 32 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Milton P. Hill, M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Sulcidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL March 11 1927

20 UNDERTAKER D. HENRY & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. [illegible] mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should s[illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

19999

## CERTIFICATE OF DEATH.

170 E 19999

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2155 Eutaw St. 22-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Andrew Wachter or SMITH

(a) RESIDENCE NO. 2155 Eutaw St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? 22 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): June 15 - 15-15

7 AGE: Years 53 Months 8 Days 23 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Hairdresser

(b) General nature of industry, business, or establishment in which employed (or employer): Swindell Bros

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Not known

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: Mrs M. C. Dougall

(Address) 34 N BENTALOU STREET

Filed MAR 11 1927 HAMPSON JONES, M. D. Registrar

Per R. L.

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/10/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to h— death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cystal Sarcoma of Chest

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) 6 yrs. mos. ds.

(Signed) Hamilton Smith M. D. (Coroner)

, 19 27 (Address) 3328 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — Date of Burial: March 12. 1927

20 UNDERTAKER: John Grebliauckas — ADDRESS: 423 S PACA ST

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

MARGIN RESERVED FOR BINDING

Spec.—1-12-23—M&T—500 Bks.

E 20000

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 20000

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2309 Garrison Ave. ST. 15-61 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ada Jane Cummins.

(a) RESIDENCE NO. 2309 Garrison Ave. ST. WARD Delaware

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert H. Cummins.

6 DATE OF BIRTH (month, day, and year) Jan. 29th 1868

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 59 | 6 | 10 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Montgomery Co. Md.

PARENTS

10 NAME OF FATHER Charles Righter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Martha Steig

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Miss Maude Righter.

(Address) 2309 Garrison Ave

15 Filed MAR 1 1927 C. HAMPTON JONES, M. D. Registrar

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9 1927

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1926, to March 9, 1927, that I last saw her alive on March 9, 1927 and that death occurred, on the date stated above, at 10.45 P. m

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus & Ovaries

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) General carcinomatosis

(duration) yrs 10 mos. ds.

18 Where was disease contracted if not at place of death? Wilmington Del.

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & laboratory findings

(Signed) Chas. Lesher Stewart, M. D.

3/9, 1927 (Address) 1738 E. 29th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wilmington Del

DATE OF BURIAL March 12 1927

20 UNDERTAKER W. M. Routson

ADDRESS 2238 N. 20th

# NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

Cor.—1-12-23—M&T—100 Blks.

E 20001

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTER

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 730 S. Durham ST., 1-13 WARD)

2-FULL NAME Michael Krial Kowski

(a) RESIDENCE NO. 730 S Durham ST., WARD
(Usual place of abode) (If non-resi

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth?

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | White | |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 70 | | | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Lithuania

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14
Informant
(Address)

15 Filed 1927 C. HAMPSON JONES, M. D.
Per Registrar

### CORONER'S CERTIF

16 DATE OF DEATH (month, da

17 I HEREBY C
remains described above, hel
thereon and from the evider
Inquy find tha
topsy or inquiry
on the day stated above.
The CAUSE OF DEATH* wa
Lober Pn

(du

CONTRIBUTORY
(Secondary)

(duration) yrs. mos

Signed Geo Custon M.D.
(Coroner)

27 192 (Address) 43 W 13 ma

*State the Disease Causing Death, or in deaths from Viole
state (1) Means and Nature of Injury, and (2) whether
Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Tr
Recent Residents.)
At place of death yrs., mos., ds. In the State yrs.,

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE O

20 UNDERTAKER — ADI

UNIVERSITY OF MARYLAND LIBRARY
Baltimore City Health

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement ... state ... OCCUPATION is very important. See instructions on back of certificate.

RETURN TO THE MORGUE

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20002

## CERTIFICATE OF DEATH.

74-001

E 20002

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St.) 5-B Ward)

2-FULL NAME George Corporal

(a) RESIDENCE NO. 1122 May St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Negro | ? |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1874

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 53 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labour

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER George Corporal

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Martha —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant

(Address)

Filed 1927 Per

C. HAMILTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1927

17

I HEREBY CERTIFY, That I attended deceased from October 16, 1926, to March 4, 1927, that I last saw him alive on March 4, 1927, and that death occurred, on the date stated above, at 11.45 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Sclerosis

Hypertension

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Central Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Laboratory

(Signed) R. Thorpe Smith, M. D.

March 6 1927 Address BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Leakin Park Date of Burial March 9 1927

20 UNDERTAKER Edward Bayne ADDRESS 1631 Pulaski St

Action should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

USE INDELIBLE PENCIL OR FOUNTAIN PEN WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information

BALTIMORE CITY HOSPITALS
UNIVERSITY OF MARYLAND
Commissioner of Health

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20003

## CERTIFICATE OF DEATH.

90 E 20003

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1800 E. Lafayette St. 8-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary H. Hauselmann

(a) RESIDENCE NO. 1800 E Lafayette St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louis C. Hauselmann

6 DATE OF BIRTH (month, day, and year): 2/18/1852

7 AGE — Years: 75 — Months: — Days: 21 19. — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country): Germany

PARENTS

10 NAME OF FATHER: Geo. Lordan

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Pauline [illegible]

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Germany

14 Informant: Karl C. Hauselmann

(Address): 1800 E Lafayette St

15 [illegible] C. HARRISON JONES, M. D.

Registrar

MAY 1 1927

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 9 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest

(Inquest, autopsy or inquiry) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Old Cerebral Thrombosis

(duration) yrs. mos. 1 ds.

May 9 1927 (Signed) F. C. Blake M. D.

(Coroner)

19 (Address) 1432 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem. — Date of Burial: May 12 27

20 UNDERTAKER: John Leitch — ADDRESS: Eden

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

~~E 20004~~ 11-081 E 20004

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 207 N Lakewood Ave St. 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Rines

(a) RESIDENCE NO. 207 N Lakewood Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo A Rines.

6 DATE OF BIRTH (month, day, and year): Nov 17 1873

7 AGE — Years: 53 — Months: 3 — Days: 20 — IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Richard Wright

11 BIRTHPLACE OF FATHER (City or town) (State or country): New York

12 MAIDEN NAME OF MOTHER: Agatha Schlenker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Geo A Rines

(Address): 207 N Lakewood

15 Filed MAR 11 1927 — C. HAMPSON JONES, M. D. Registrar

Per NRH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: March 9 - 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 28, 1927, to Mch 9, 1927, that I last saw her alive on Mch 9, 1927, and that death occurred, on the date stated above, at 7.40 P m.

The CAUSE OF DEATH* was as follows:

Grippe & Toxic pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Cardiac Dilation

(duration) yrs. mos. 10 ds.

18 Where was disease contracted: Balt

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Chas F Blake, M. D.

19 (Address) 20 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cem

Date of Burial: Mar 13 1927

20 UNDERTAKER: John Ulrich

ADDRESS: 200 S Arlington

Spec.—1-10-21—M&T—1500 Bks.

E 20005 HEALTH DEPARTMENT—CITY OF BALTIMORE 199 E 20005

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Womans Hospital

CITY OF BALTIMORE: (No. Lem & Lafayette ST. 12-19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen German.

(a) RESIDENCE NO. 1700 Greenmount Ave. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. 6 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced ~~HUSBAND~~ WIFE of Jonathan German

6 DATE OF BIRTH (month, day, and year) 4-3-1907

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 19 | 6 | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Charles Yeager

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Ella Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Jonathan German—Husband. (Address) 1706 Greenmount Ave.

15 Filed 3/21 1927 C. [illegible] U.S.I. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-9-27 19

17

I HEREBY CERTIFY, That I attended deceased from March 8th 19 27 to March 9th 19 27.

that I last saw he alive on March 9th 19 27.

and that death occurred, on the date stated above, at 7.28 P. m.

The CAUSE OF DEATH* was as follows:

Acute Streptococcus Peritonitis.

following self induced Abortion

(duration) 1 day, yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? yes Date of Mar 8-27

Was there an autopsy? no

What test confirmed diagnosis? Operation - Bacteriological

(Signed) Wm. Wilson, M. D.

3/9 1927 (Address) Women's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL 3/14 1927

20 UNDERTAKER Chas. E. Brand & Son — ADDRESS 118 W. Mt. Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 20006

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 20006

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. U. S. Marine Hosp. ST. 12-51 WARD)

2-FULL NAME Francis Higgins

(a) RESIDENCE NO. U. S. Marine Hospital ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 6, 1859

7 AGE — Years: 67 — Months: 3 7 — Days: 5 25 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Steward

(b) General nature of industry, business, or establishment in which employed (or employer): Seaman

(c) Name of employer: Sch. Agnes Drillan

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Michel Higgins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Elizabeth McGeney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Self.

(Address)

15 Filed 1927 HAMILTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 11 1927

17

I HEREBY CERTIFY, That I attended deceased from May 4 1926 to Mar. 11 1927,

that I last saw him alive on Mar. 11 1927,

and that death occurred, on the date stated above, at 12:10 a. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac decompensation,

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) #1 Mitral insufficiency, #2 arteriosclerosis gangrene of foot. #1 unknown. (duration) yrs. mos. #2 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes. Date of Mar. 4 1927

Was there an autopsy? No.

What test confirmed diagnosis? laboratory and clinical

(Signed) P. Hagerman, M. D.

, 19 (Address) U. S. Marine Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: 3/12 1927

20 UNDERTAKER: Chas. B. Crane & Son 118 W. Mt. Royal ave

ADDRESS

Filed R 1 1927

Permit

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 20007

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20007

## CERTIFICATE OF DEATH.

148

1-PLACE OF DEATH Woman's Hospital

CITY OF BALTIMORE: (No. John & Lafayette St. 11-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Evelyn Pope Gillet

(a) RESIDENCE NO. Glyndon Md. ST., ..... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 3 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | White | married |

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Charles B. Gillet.

6 DATE OF BIRTH (month, day, and year) Nov 27th 1899

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 28 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... House-work 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kentucky

PARENTS

10 NAME OF FATHER Felix Taylor Pope

11 BIRTHPLACE OF FATHER (city or town) Lake Brondin (State or country) La

12 MAIDEN NAME OF MOTHER Jackie Lea Sale

13 BIRTHPLACE OF MOTHER (city or town) Collinville (State or country) Texas

14 Informant Mrs Charles B Gillet

(Address) Worthington Valley

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10, 1927.

17

I HEREBY CERTIFY, That I attended deceased from March 8, 1927. to March 10. 1927.

that I last saw h er alive on March 10, 1927,

and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:

Nephritis toxemia of pregnancy

(duration) about 1 month yrs. mos. dys.

CONTRIBUTORY (Secondary) Acute pulmonary edema

(duration) 1 hour yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? no! Date of

Was there an autopsy? yes!

What test confirmed diagnosis? exam. of lung.

(Signed) W. M. Wilson, M. D.

3-10, 1927 (Address) Women's Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Thomas Garrison Forest

DATE OF BURIAL March 12 1927

20 UNDERTAKER Henry Jenkins & Son

ADDRESS Edward McCollett

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

20008 20008

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Woman's Hospital

CITY OF BALTIMORE: (No. John & Lafayette St. 14-20 161 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME (Baby Gillet)

(a) RESIDENCE NO. Eylandan md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | new-born |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 3-10-27

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | | | | 35 minutes |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — Infant

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Charles B. Gillet

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Evelyn Pope

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kentucky

14 Informant Mr Charles B. Gillet

(Address) Worthington Valley

15 Filed MAR 11 1927, 19 C. HAMPSON JONES, M. D. Registrar

Per A.R.H.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10, 1927

17

I HEREBY CERTIFY, That I attended deceased from March 10, 1927, to —, 19 .

that I last saw him alive on March 10, 1927,

and that death occurred, on the date stated above, at 12:30 P. m.

The CAUSE OF DEATH* was as follows:

Pre-maturity + congenital atelectasis.

(Post-mortem Caesarian section.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Failed to breath.

(Signed) Wm. Wilson, M. D.

3-10, 1927 (Address) Woman's Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. St Thomas Garrison Forest DATE OF BURIAL March 12 1927

20 UNDERTAKER Henry W Jenkins Sons Co ADDRESS Edmondson Ave & Caton

IMPORTANT.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20009

E 20009

## CERTIFICATE OF DEATH.

REGISTERED NO. C 12-5912 9

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2423 Madison av St.) 12-5912 9 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lizzetta B. Collins

(Residence in Baltimore: No. 2423 Madison av St.; 4 yrs., mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, January 1st, 1882 (Month) (Day) (Year)

7-AGE, 45 yrs. 2 mos. 9 ds.

If LESS than 1 day, ....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Grey Rock Balto Co

PARENTS.

10-NAME OF FATHER. Josiah Farland

11-BIRTHPLACE OF FATHER (State or Country). unknown

12-MAIDEN NAME OF MOTHER Ella Bell

13-BIRTHPLACE OF MOTHER (State or Country). Granite Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eugene Collins

(Address) 2423 Mad ave

15-

Filed, OCT 1 1927 C. HAMPSON JONES, M. D. Registrar. Per

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 3 (Month) — 9 (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 1/25 1927, to 3/9 1927, that I saw h[er] alive on 3/9 1927, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Intussusception Neoplastic

(Duration) yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) acute Cardiac Dilatation

(Duration) yrs. mos. 1 ds.

(Signed) Gustav Goldman M. D.

3/10, 1927 (Address) 856 Wdale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn cem

DATE OF BURIAL, 3.12, 1927

20-UNDERTAKER J Leon Hall

ADDRESS 703 Dolphin

sc

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20010

## CERTIFICATE OF DEATH

× 57

E 20010

1-PLACE OF DEATH University Hospital

REGISTERED NO.

4-30

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. St. Ward)

2-FULL NAME Ida Pitzer

(a) RESIDENCE NO. 321 N. Queen St Martinsburg, W.Va. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. / ds. How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of W. E. Pitzer.

6 DATE OF BIRTH (month, day, and year) ? 1868

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 59 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Henry Shrimp

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Lydia Burcher

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ohio

14 Informant Hospital Records

(Address) University Hospital

15 Filed MAR 11 1927 C. HAMPSON JONES, M. D. Registrar

Per ACH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/11/27 19

17 I HEREBY CERTIFY, That I attended deceased from 3/10/27, 19, to 3/11/27, 19,

that I last saw her alive on 3/11/27, 19,

and that death occurred, on the date stated above, at 10 A.M. m.

The CAUSE OF DEATH* was as follows:

Diabetic & Uremic Coma (Coma)

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Terminal Broncho Pneumonia.

(duration) yrs. mos. ½ ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? yes Date of 3/2/27

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Laboratory

(Signed) J. S. Winstead, M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Martinsburg. W.Va.

Date of Burial March 11 1927

20 UNDERTAKER H. M. Cole.

ADDRESS 115 S. Maple Ave. Martinsburg W.Va.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is very important. See instructions on back of certificates.

MAR 11 1927

Spec.—12-9-25—A Co.—200 Blks.

E 20011

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20011

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [illegible] St. 76-29 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Eaton

(a) RESIDENCE NO. Phoenix Md. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. da.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. da.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ella Eaton

6 DATE OF BIRTH (month, day, and year) [illegible] 5

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 72 | 72 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Labour 40

(b) General nature of indastry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Baltimore County Md

PARENTS

10 NAME OF FATHER William E. Eaton

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Baltimore County Md

12 MAIDEN NAME OF MOTHER Agnes Imple

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Baltimore County

14 Interment (Address) (Records)

15 Filed, 19 Per Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8 1927

17

I HEREBY CERTIFY, That I attended deceased from March 7, 1927, to March 8, 1927, that I last saw him alive on March 8, 1927, and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:

Senility

Acute Myocarditis

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General & Labratory

(Signed) R. Hooper Lovell, M. D.

Md 4 9 27 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Glenecoe Baltimore Co. Date of Burial: March 12, 27

20 UNDERTAKER: Chenoweth & Son ADDRESS 3417 Chestnut St.

MAR 11 1927 C. HAMSON COLE, M. D.

BALTIMORE CITY HOSPITALS

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20012

# CERTIFICATE OF DEATH.

E 20012

1-PLACE OF DEATH Mercy Hospital

City of BALTIMORE: (No. 1 St. 13-52 Ward) 65-081

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Wheeler

(a) RESIDENCE NO. 4138 Falls Road St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 Color or Race White

5 Single, Married, Widowed, or Divorced, (write the word) Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 18, 1910

7 AGE — Years 16 — Months 11 10 — Days 23 — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Printer 03

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER James Wheeler

11 BIRTHPLACE OF FATHER (city or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Bessie E. Fisher

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant James Wheeler

(Address) 4138 Falls Road

15 Filed MAR 11 1927 E. HARRISON JONES, M. D.

Per OKH Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 22, 1927, to March 11, 1927, that I last saw h[illegible] alive on March 11, 1927, and that death occurred, on the date stated above, at 11^10 A. m.

The CAUSE OF DEATH* was as follows:

Lymphatic Leukemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

What test confirmed diagnosis?

(Signed) H. Guerta, M. D.

, 19 (Address) Mercy Hospital City

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — Date of Burial March 15th 27

20 UNDERTAKER Chenowith & Son — ADDRESS 3615 Chestnut Ave

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

# E 20013

## CERTIFICATE OF DEATH

129 E 20013

(REGISTERED NO.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 213 S. Mount St. 19-28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George A. Wolf.

(a) RESIDENCE NO. 213 S. Mount St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna Wolf.

6 DATE OF BIRTH (month, day, and year): April 24 1858

7 AGE: Years 68. Months 10 Days 15

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md.

PARENTS

10 NAME OF FATHER: Matthias Wolf.

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Josephia Menschier

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Germany

14 Informant: Charles Wolf.

(Address): 1930 Harlem Ave.

15 Filed R 11 1927

C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 9, 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 16, 1927, to Mar 9, 1927, that I last saw h— alive on Mar 8, 1927, and that death occurred, on the date stated above, at 11. A. m.

The CAUSE OF DEATH* was as follows: Chronic Nephritis - Exhaustion - Natural Negligence

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) James L. Kirkpatrick M. D.

3/11 1927 (Address) 1799 E. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mar. Cathedral — Date of Burial: Mar 12 1927

20 UNDERTAKER: Wendell J. Klippel — ADDRESS: 320 S Eden St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 20014

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20014

## CERTIFICATE OF DEATH.

100-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 708 E. Dorsey ST. 17-24 WARD)

2-FULL NAME Lester Davenport

(a) RESIDENCE No. 708 E. Dorsey .ST., ... WARD ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 17-26

7 AGE Years Months 2 Days 24 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Walter Davenport

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Annie Trusty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Walter Davenport
(Address) 708 E. Dorsey St

15 Filed ... 19... By ... Registrar

C. HAMPSON JONES, M. D.

APR 12 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11 1927

17 I HEREBY CERTIFY, That I attended deceased from March 6, 1927, to March 11, 1927, that I last saw h[illegible] alive on March 11, 1927, and that death occurred, on the date stated above, at 11:30 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Primary) (duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) H. C. Jones, M. D.

, 19 (Address) 823 Dorsey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem

DATE OF BURIAL 3/12/27

20 UNDERTAKER James L. Kirby

ADDRESS 1711 E. Baltimore St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20015

## CERTIFICATE OF DEATH

E 20015

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Provident Hospital St. 17-2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Jones

(a) RESIDENCE NO. 813 Harlem Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | Col | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1889

| 7 AGE Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|
| 38 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md

PARENTS

10 NAME OF FATHER Laurence Jones

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Alice Snowden

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Alice Jones

(Address) 813 Harlem Ave.

15 Filed MAR 12 1927 19 C. HAMPSON JONES, M. D. Registrar

Per RRH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-10-1927

17 I HEREBY CERTIFY, That I attended deceased from 3-7-, 1927, to 3-10-, 1927, that I last saw him alive on 3-10-, 1927, and that death occurred, on the date stated above, at 2.30 p m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

Pulmonary Edema

Influenza

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Extravasation of Urine

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 3-7-27

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) C. Hampson Jones M. D.

3-10-, 1927 (Address) 808 W. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

Date of Burial 3/14/27

20 UNDERTAKER Samuel Hemsley

ADDRESS Balto

NO. 1.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item on this form should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 20016 831

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

101 E 20016

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 15-21 S. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doris Hill

(a) RESIDENCE NO. 1618 Presstman ST. City WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov. 10. 25

7 AGE: Years 1 Months 4 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: William Green

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Cora Hill

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Parents.

(Address) JOHNS HOPKINS HOSP.

15 Filed MAR 12 1927 Registrar: G. HAMPSON JONES, M. D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 10 1927

17

I HEREBY CERTIFY, That I attended deceased from March 4, 1927, to March 10, 1927,

that I last saw he alive on March 10, 1927

and that death occurred, on the date stated above, at 3 20 p. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia (acute)

(duration) 0 yrs. 0 mos. 10 ds.

CONTRIBUTORY (Secondary): None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1618 Presstman St.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) W. S. Handley, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem. DATE OF BURIAL: 3/13/27

20 UNDERTAKER: Samuel Hemsley ADDRESS: W. Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Rittase)

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20017 E 20017

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mer Lee Hospital 3-13-27 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Sarah Rachael Rittase

(a) RESIDENCE No. 3700 Rail Road Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? 6 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jno A Rittase

6 DATE OF BIRTH (month, day, and year) July 1862

7 AGE Years 64 Months 7 Days ? If LESS than 1 day, ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER J Stokes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Mary Locke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Mrs Rachael Rittase (Address)

15 Filed ....., 19..... Per ..... C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/11 1927

17 I HEREBY CERTIFY, That I attended deceased from 1/22, 1927, to 3/11, 1927, that I last saw h[illegible] alive on 3/11, 1927, and that death occurred, on the date stated above, at 9:55 P m.

The CAUSE OF DEATH* was as follows: Carcinoma of Liver

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Generalized carcinomatosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of 2/26/27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno A Rittase, M. D.

, 19 (Address) Med and Surgeon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Christ Church Cemetery DATE OF BURIAL May 14-27

20 UNDERTAKER A S Marshall ADDRESS 3539 Fall Rd

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

R 12 1927

Spec.—1-10-21—M&T—1500 Blks.

E 20018

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20018

## CERTIFICATE OF DEATH.

REGISTERED NO. 179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1406 Ramsay St., 14-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William B. Shipley

(a) RESIDENCE NO. 1406 Ramsay ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Martha E. Shipley

6 DATE OF BIRTH (month, day, and year) Dec 3, 1872

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 54 | 3 | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Jessie Shipley

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Mrs Martha Shipley
(Address) 1406 Ramsay St.

15 Filed MAR 12 1927, 19 C. HAMPSON JONES, M. D. Registrar
By .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 1 1926 to March 9 1927
that I last saw ~~him~~ alive on March 9 1927
and that death occurred, on the date stated above, at 8.15 P. m.
The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of ....

Was there an autopsy? No

What test confirmed diagnosis? Usual Urinary

(Signed) Roberto Troncoso M. D.

, 19 (Address) 455 Hollins St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Loudon Park | Mar 12 1927 |
| 20 UNDERTAKER | ADDRESS |
| Harry H. Witzke | 150 W Lanvale St |

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20019

# CERTIFICATE OF DEATH

101-001

E 20019

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 317 S. Eden St. 3-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kazmierz Jaskulski

(a) RESIDENCE NO. 317 S. Eden St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Julia Jaskulski

6 DATE OF BIRTH (month, day, and year) May 1-1881

| 7 AGE | Years | Months | Days | IF LESS than 1 day ... hrs. or ... min. |
|---|---|---|---|---|
| 46 | 45 | 0 | 11 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor 80

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Poland

(State or country)

PARENTS

10 NAME OF FATHER Joseph Jaskulski

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Caroline Sawicki

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Julia Jaskulski (Wife)

(Address) 317 S. Eden St.

15 Filed C. HAMILTON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11 1927

17 I HEREBY CERTIFY, That I attended deceased from March 7 1927 to March 11 1927

that I last saw h... alive on March 11 1927

and that death occurred, on the date stated above, at 3.35 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Will Thyson M. D.

(Address) 806 Kenyon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Date of Burial 3/14 1927

20 UNDERTAKER Wm Trackowski ADDRESS 618 Eastern Ave.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

R 12 1927

Spec.—1-12-23—M&T—500 Blks.

E 20020

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20020

## CERTIFICATE OF DEATH.

13-59 29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2545 Francis St., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Ludwig

(a) RESIDENCE No. 2545 Francis ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 2 mos. 19 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 1855

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs or ... min |
|---|---|---|---|---|
| | 71 | 2 | 19 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Conrad Ludwig

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Julia Birmuller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Jno B. Ludwig

(Address) 2545 Francis

15 Filed MAR 12 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1927

17 I HEREBY CERTIFY, That I attended deceased from October 13, 1925, to March 10, 1927, that I last saw him alive on March 7- 1927 and that death occurred, on the date stated above, at 5 a m

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Chronic Int. Nephritis (duration) Remit yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. E. Buxton, M. D.

3/11 1927 (Address) 302 East Conn Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Mch 12 1927

20 UNDERTAKER H. J. Tudor & Son — ADDRESS N. St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20021

## CERTIFICATE OF DEATH.

90 E 20021

1-PLACE OF DEATH

City of BALTIMORE: (No. 110 S Robinson St., 1-2 Ward)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edna F. Lehardy

(a) RESIDENCE NO. 110 S Robinson St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, ~~or divorced~~ ~~HUSBAND of~~ (or) WIFE of: Louis Lehardy

6 DATE OF BIRTH (month, day, and year): 1893

7 AGE — Years: 34 — Months: — Days: — IF LESS than 1 day.....hrs. or.....min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 031

(c) Name of employer: —

9 BIRTHPLACE (city or town): City

(State or country): Md

PARENTS

10 NAME OF FATHER: Charles Arnold

11 BIRTHPLACE OF FATHER (city or town): —

(State or country): Germany

12 MAIDEN NAME OF MOTHER: don't know

13 BIRTHPLACE OF MOTHER (city or town): —

(State or country): Germany

14 Informant: Louis Lehardy

(Address): 110 S. Robinson St

15 Date: 1 2 1927 Per _____ C. HAMPSON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 9 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ~~h~~ her death on the day stated above.

The CAUSE OF DEATH* was as follows: —

Mitral Stenosis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

(Signed) Geo Lenhardt Hadley M.D. (Coroner)

(Address) 1436 Bray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery Date of Burial 3/12/1927

20 UNDERTAKER: J. A. Moran ADDRESS 300 E Balt St.

tion should be carefully supplied. AGE should be stated OF DEATH in plain terms, so that it may be properly very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

(Doelle)

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20022

E 20022

107-003

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Josephs Hospital

CITY OF BALTIMORE: (No. Caroline & Oliver St. 8-16 WARD)

2-FULL NAME Mrs Teresa Doelle

(a) RESIDENCE NO. 2127 Fenwick Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Doelle

6 DATE OF BIRTH (month, day, and year) Aug 26 1894

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or ... min. |
|---|---|---|---|---|
| | 32 | 6 | 16 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Geo Hillenbrand

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Ch. Gossman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Henry Doelle

(Address) 912 N. Mullen Ave

FEB 2 1927 C. HAMPSON JONES, M. D. Registrar

Per AKH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11 1927

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1927, to March 11, 1927,

that I last saw her alive on March 11, 1927,

and that death occurred, on the date stated above, at 7:20 p. m.

The CAUSE OF DEATH* was as follows:

Lung. Abscess. (Fatal)

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Cardiac dilatation.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? yes. Date of ?

Was there an autopsy? no.

What test confirmed diagnosis? clinical.

(Signed) Frank R. DeSaulles, M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Mar 14 1927

20 UNDERTAKER Geo M. Frank & Son — ADDRESS 911 N Wolfe

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of [illegible] is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20023

## CERTIFICATE OF DEATH.

89

E 20023

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital Ward)

2-FULL NAME Louis Vincent

(a) RESIDENCE NO. 120 Monroe St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? — yrs. — mos. — ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | white | Md |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Carroll

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 56 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Policeman

(b) General nature of industry, business, or establishment in which employed (or employer) Balto City

(c) Name of employer

9 BIRTHPLACE (city or town) Washington D.C.

(State or country)

PARENTS

10 NAME OF FATHER John Vincent

11 BIRTHPLACE OF FATHER (city or town)

(State or country) England

12 MAIDEN NAME OF MOTHER — Mommonier

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Maryland

14 Informant Paul J. Vincent

(Address) 3200 Hutzlers Falls Parkway

15 Filed ..... 19 ..... C. HARRY JONES, M. D.

Per ..... Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said Inquest

(Inquest, autopsy or inquiry) ....find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cause Pedarus

Sudden (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Kidney

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Mahoney, M. D.

(Coroner)

March 12 27, 19 (Address) 120 16 Monroe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) Ten minutes

At place of death ....yrs., ....mos., ....ds. In the State ....yrs., ....mos., ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

St. Mary's Cem. Govans 3/14 19 27

20 UNDERTAKER — ADDRESS

Henry W. Mears & Son 805 N. Calvert St.

MAR 12 1927

don should be carefully supplied. AGE should be stated OF DEATH in plain terms, so that it may be properly very important. See instructions on back of certificate.

stated EXACTLY. PHYSICIANS shou state C ... N is erly classified. Exact statement of OCCUPA ficate.

Cor.—12-9-25—A Co.—200 Bks.

E 20024

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20024

## CERTIFICATE OF DEATH.

REGISTERED NO. 171

1-PLACE OF DEATH

City of BALTIMORE: (No. 1937 Penna Ave. St. 14-2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. H. Scott

(a) RESIDENCE NO. 1937 Penna Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | colored | single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 24 1879

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 47 | 9 | 21 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer General

9 BIRTHPLACE (city or town) Charles Co. Md.

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Mrs. Bettie Rosebud

(Address) 1937 Penna Ave.

15 Filed 12 1927 C. HAMPSON JONES, M. D.

Per Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) March 16, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Caused by Laceration of throat. (Razor) (duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. J. Hennessy M. D.

(Coroner)

19 27 (Address) 3802 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laplata. Md Charles Co. Md Date of Burial Mar. 18 19 27

20 UNDERTAKER Mrs Geo N. Dennis Per T. G. Kelso ADDRESS 1703 Pressman St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20025

E 20025

43

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St., 5-8 Ward)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Smith

(a) RESIDENCE NO. Levering House St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1874

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 53 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labour

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Maryland

PARENTS

10 NAME OF FATHER Patrick Smith

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Lizzie —

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Ireland

14 BALTIMORE CITY HOSPITALS

Informant [redacted]

(Address) Records

R 12 1927 C. HAMPSON JONES, M. D.

Per _____ Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1927

17

I HEREBY CERTIFY, That I attended deceased from February 28, 1927, to March 4, 1927, that I last saw him alive on March 3, 1927, and that death occurred, on the date stated above, at 5.45 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma Tongue

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Gen'l & Labrodey

(Signed) R Hooper Smith, M. D.

Mar (Y 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart — Date of Burial 3/12 1927

20 UNDERTAKER J. J. Fahy Sons — ADDRESS 1318 Light St

Don should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

E 20026

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20026

90

## CERTIFICATE OF DEATH

1-PLACE OF DEATH Union Memorial Hospital REGISTERED NO.

City of BALTIMORE: (No. 33rd & Calvert St. 2748 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary E. Street

(a) RESIDENCE NO. 500 Abington Ave Govans St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1852

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 45 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland (State or country)

PARENTS

10 NAME OF FATHER James Gardner

11 BIRTHPLACE OF FATHER (City or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Mary Shaeen

13 BIRTHPLACE OF MOTHER (city or town) Pa (State or country)

14 Informant E. Gardner

(Address) 17 Fair Court

C. HAMPSON JONES, M. D.

Registrar

12 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1927

17 I HEREBY CERTIFY, That I attended deceased from March 9, 1927, to March 10, 1927

that I last saw h. alive on March 10, 1927,

and that death occurred, on the date stated above, at 1—P m.

The CAUSE OF DEATH* was as follows:

Hypertension, Myocarditis

? (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

? (duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) James Arthur Gardner, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem Date of Burial Mar 12 1927

20 UNDERTAKER E. LeRoy Stiffler ADDRESS 1155 Nat Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state C... OF DEATH in plain terms, so that it may be properly classified. Exact statement of O...UPA...ON is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 20027

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

123

E 20027

REGISTERED NO. 13759

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Lake Drive Apts. ST.; (5 WARD)

2-FULL NAME Fannie L. Burgunder

(a) RESIDENCE NO. Lake Drive Apts. ST.; 5 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jany. 27, 1850

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 77 | 1 | 14 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cumberland, Md.

PARENTS

10 NAME OF FATHER Joseph Burgunder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bavaria

12 MAIDEN NAME OF MOTHER Esther Bergman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bavaria

14 Informant Mrs. I. Baer

(Address) Lake Drive Apts.

Filed MAR 12 1927, 19 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/11/1927.

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1925, to March 11, 1927,

that I last saw h[illegible] alive on March 10, 1927

and that death occurred, on the date stated above, at 6.10 P m

The CAUSE OF DEATH* was as follows:

Chronic Cholecystitis and Cholelithiasis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? usual

(Signed) Edwin F. Mayer, M. D.

3/11, 1927 (Address) The Esplanade

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ohel Shalom Cem. DATE OF BURIAL 3/14/1927

20 UNDERTAKER David Londheim ADDRESS 118-20 W. Mt. Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 20028

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20028

## CERTIFICATE OF DEATH.

11-002

21-29

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 620 Scott ST., WARD)

2-FULL NAME Mary C. Langlotz

(a) RESIDENCE NO. 620 Scott ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William C. Langlotz

6 DATE OF BIRTH (month, day, and year) Aug. 5, 1834

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min |
|---|---|---|---|---|
| | 92 | 6 | 4 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, bnsiness, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. George E. Bollman
(Address) 620 Scott St.

15 Filed MAR 12 1927 C. HAMPSON JONES, M. D. Registrar
Per .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 9, 1927

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1927, to March 9, 1927, that I last saw h.. alive on March 9, 1927, and that death occurred, on the date stated above, at 6.30 a. m.

The CAUSE OF DEATH* was as follows:

Senile Decay

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) La Grippe

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) C. Hampson Jones, M. D.

March 11, 1927 (Address) 61 Lodor

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL Mar 12 1927

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OC- CPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20029

## CERTIFICATE OF DEATH.

X 75 E 20029

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 410 Massachusetts Av. ST., 26-71 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Francis Jennings

(a) RESIDENCE NO. 410 Massachusetts Av. ST., 26th WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where d... yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 10 d 1848

7 AGE — Years: 78 Months: 6 Days: — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Richardsville Va

10 NAME OF FATHER: [illegible]

PARENTS

11 BIRTHPLACE OF FATHER (city or town) (State or country): Richardsville Va

12 MAIDEN NAME OF MOTHER: Elizabeth Jennings

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Richardsville Va

14 Informant: Lucy J. Riley

(Address) 410 Massachusetts Av

15 Filed MAR 12 1927, 19... C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 10th 1927

17 I HEREBY CERTIFY, That I attended deceased from March 4, 1927, to March 10, 1927.

that I last saw her alive on March 10, 1927.

and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) W. A. Kuell, M. D.

March 31, 1927 (Address) Irvington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Richardsville Va

DATE OF BURIAL: March 13 1927

UNDERTAKER: J. B. Hilyard & Son

ADDRESS: Richardsville Va

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 20030 HEALTH DEPARTMENT—CITY OF BALTIMORE E 20030

# CERTIFICATE OF DEATH.

162

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hospital STREET 9-16 WARD)

2-FULL NAME Kenneth R. Leaman

(a) RESIDENCE NO. 212 2d Hanford Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. 1 ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 10 1927

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | | | 1 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Kenneth R. Leaman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Florida.

12 MAIDEN NAME OF MOTHER Bonita W. Hutton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mr Kenneth R Leaman

(Address) 212 2d Hanford Ave

15 Filed MAR 21 1927, 19. E. HAMPSON JONES, M. D., Registrar

By [illegible]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11 1927

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1927, to March 11, 1927, that I last saw him alive on March 11, 1927, and that death occurred, on the date stated above, at 7 45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lumbar Puncture

(Signed) L. W. Kraeer, M. D.

, 19 (Address) 1512 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cemetery buried other

DATE OF BURIAL March 12, 1927

20 UNDERTAKER Henry Hoen Son

ADDRESS [illegible]

TION is very important See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 20031 | 129 E 20031

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 819 Hillow St. 10th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Willis

(a) RESIDENCE NO. 819 Hillow St. 10 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widower |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 5 1856

| 7 AGE | Years | Months | Days | IF LESS than 1 day ... hrs. or ... min.. |
|---|---|---|---|---|
| | 70 | 8 | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ... None

(b) General nature of industry, business, or establishment in which employed (or employer) ... 000

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md

(State or country)

PARENTS

10 NAME OF FATHER Robert Willis

11 BIRTHPLACE OF FATHER (City or town) Ireland.

(State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Kn

(State or country)

14 Informant Mr. Michael Willis

(Address) 819 Willis St

15 Filed 2 1927 C. HAMPSON JONES, M. D. Registrar

Per ...

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Feby 14 1927 to March 10 1927

that I last saw h. alive on March 10 1927

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Ch Interstitial Nephritis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. G. Hamilton, M. D.

3/14 1927 (Address) 733 Arlington St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Mt Cathedral Cemetery — March 14 1927

20 UNDERTAKER — ADDRESS

Henry Hook & Son — Belle & Lynn

---

...should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20032

## CERTIFICATE OF DEATH.

188-0032 ✓ E 20032

REGISTERED NO. _____

1-PLACE OF DEATH

City of BALTIMORE: (No. 721 Ensor St. 10-14 St. _____ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julius Venable

(a) RESIDENCE NO. 721 Ensor St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | col | single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1/24

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 2 | 9 | 8 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER Julius Venable

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Maud Wright

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant

(Address) 721 Ensor St

15 Filed C. HAMPSON JONES, M. D. Registrar

MAR 12 1927 Per A.H.N.

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 9 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Crushed head - thrown by auto truck 721 Ensor St accident.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Fallin M. D.

(Coroner)

3-12 1927 (Address) 505 E Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Cem Date of Burial Mar 12 1927

20 UNDERTAKER Mrs. R. A. Elliott ADDRESS 1225 Eutaw

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20033

100-001 E 20033

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St. 6-9 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lewis E Watkins.

(a) RESIDENCE NO. 1708 Mulliken St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | C | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lindsman

6 DATE OF BIRTH (month, day, and year) 1873

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 54 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER Lindsman

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Lindsman

12 MAIDEN NAME OF MOTHER Lindsman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Lindsman

14 Informant (Address) 1708 Mulliken St

15 Filed 2 1927 C. HAMPSON JONES, M. D. Registrar

Per

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

Contributory (Secondary) Arteriosclerosis (duration) yrs. mos. 1 ds.

Contributory (Secondary) Myocarditis (duration) yrs. mos. 1 ds.

Signed Mac Gates M. D.

(Physician)

Address 1343 E Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.,.....ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Calvary. Date of Burial May 12/27

20 UNDERTAKER Wm. P. G. Elliott ADDRESS 1325 Eutaw.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 20034

# HEALTH DEPARTMENT—CITY OF BALTIMORE

10 E 20034

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1833 Brunt St., 14-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isaiah Watkins

(a) RESIDENCE NO. 1833 Brunt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colord | Married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1878

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 49 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Isaac Watkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary A. Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Helen Watkins

(Address) 1833 Brunt St

15 Filed MAR 12 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb 27, 1927, to March 10, 1927, that I last saw h alive on March 10, 1927, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Pyothyphlitis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Bruce Hoag, M. D.

Mch 14, 1927 (Address) 2 Queen's Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Queenstown Md DATE OF BURIAL March 12-27

20 UNDERTAKER Dennis Carton ADDRESS 916 Eager ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20035

90 E 20035

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St., 16-26 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Burton

(a) RESIDENCE NO. 853 W. Lexington St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Negro | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lizzie Burton

6 DATE OF BIRTH (month, day, and year) 1856

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 71 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Va

PARENTS

10 NAME OF FATHER Albert M. Burton

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Lucy Green

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant (Address) BALTIMORE CITY HOSPITALS

C. HAMPSON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9 1927

17

I HEREBY CERTIFY, That I attended deceased from January 13, 1927, to March 9, 1927, that I last saw him alive on March 9, 1927, and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Sclerosis

Chronic Myocarditis & Senile Dementia

(duration) yrs. mos. ds.

CONTRIBUTORY Myocardial Failure

(Secondary)

(duration) yrs. 9 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? general & Laboratory

(Signed) R. Hoopes Knull, M. D.

March 12 1927 Address BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Date of Burial March 12th 1927

20 UNDERTAKER Daniel Easton ADDRESS 916 Eager

MAR 12 1927

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20036

## CERTIFICATE OF DEATH.

E 20036

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1410 Linden ave. ST., 14-20 WARD)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Corbett

(a) RESIDENCE NO. 1410 Linden ave. ST., ... WARD ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | white | Married |

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Ann Corbett

6 DATE OF BIRTH (month, day, and year) July 22, 1863

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 63 | 7 | 20 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Realtor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10 NAME OF FATHER John Corbett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Margret Watson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Dr R. Corbett

(Address) 524 Harvard St. Montreal

15 C. HAMPSON JONES, M. D. Registrar

12 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 12 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 16, 1927. to Mar. 12 1927.

that I last saw him alive on March 11 1927.

and that death occurred, on the date stated above, at 4.20 a. m.

The CAUSE OF DEATH* was as follows:

Arteris. Sclerosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) — yrs. — mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of ...

Was there an autopsy? no

What test confirmed diagnosis? Clinical Findings

(Signed) John A. Buchness M. D.

19 (Address) 375 S. Fricton St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Montreal Canada

DATE OF BURIAL Mar 15 1927

20 UNDERTAKER Robert Brookerson

ADDRESS Calhoun Hollins

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20037

E 20037

## CERTIFICATE OF DEATH.

REGISTERED NO. 57

1-PLACE OF DEATH St Josephs Hospital

CITY OF BALTIMORE: (No. Caroline & Oliver ST. 8-44 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Catherine Leitschuh.

(a) RESIDENCE No. 2612 Overland ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, or Divorced, (write the word): ~~Divorced~~ Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: None.

6 DATE OF BIRTH (month, day, and year): Nov 17/91

7 AGE: Years 35 | Months 5 | Days 22 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER D. Leitschuh

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER Mary Leitschuh.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant Mr. Daniel Leitschuh

(Address) 2612 Overland ave

15 Filed 2 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 4 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb 27, 1927, to March 4, 1927, that I last saw her alive on March 4, 1927, and that death occurred, on the date stated above, at 6:00 p m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus.

Cholecystitis.

Myocarditis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? — Date of —

Was there an autopsy? None

What test confirmed diagnosis? Clinical.

(Signed) Clement B. Wood, M. D.

, 19 (Address) St Josephs Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery. March. 14 1927

DATE OF BURIAL

20 UNDERTAKER: George J. Ruth. 1735 Harford ave

ADDRESS

TION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20038

## CERTIFICATE OF DEATH

× 129

E 20038

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 217 E. 21st St. 12-19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Ebenezer Shields

(a) RESIDENCE NO. 217 E. 21st St. Ward Cumberland Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Laura Shields

6 DATE OF BIRTH (month, day, and year): April 9, 1852

7 AGE: Years 74 Months 11 Days 2 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Gov. Employee

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer: P.O. Cumberland, Md.

9 BIRTHPLACE (city or town)

(State or country): Maryland

PARENTS

10 NAME OF FATHER: James Shields

11 BIRTHPLACE OF FATHER (City or town)

(State or country): U. S.

12 MAIDEN NAME OF MOTHER: Anna Lanahan

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): United States

14 Informant: Mrs. Myra Dean

(Address): 217 E. 21st St.

15 Date: 3 12 1927 Registrar: C. HAMPSON JONES, M. D.

Per

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: March 11, 1927

17 I HEREBY CERTIFY, That I attended deceased from March 27, 19 to March 11, 19 27.

that I last saw h alive on 3-10, 19 27.

and that death occurred on the date stated above, at 10 p m.

The CAUSE OF DEATH* was as follows:

I Chronic Hypertension

Mitral Regurgitation

(duration) yrs. 1/2 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Pending

(Signed) F. Ed Burgess, M. D.

3-12, 1927 (Address) 800 N. Patterson Pk. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cumberland, Md.

Date of Burial: Mar. 12 '27

20 UNDERTAKER: Joseph B Cook

ADDRESS: 103 Baltimore St

Spec.—1-12-23—MAT—500 Bks.

E 20039

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20039

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 200 S. 3rd (ST.) Brooklyn (WARD) 16

REGISTERED NO. 1595

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harold E Geis Jr

(a) RESIDENCE NO. 200 S 3rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | W. | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 10 1927

| 7 AGE Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|
| | | 2 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — nun

(b) General nature of industry, business, or establishment in which employed (or employer) — nun

(c) Name of employer — God

9 BIRTHPLACE (city or town) (State or country) Brooklyn Md

PARENTS

10 NAME OF FATHER Harold E Geis Jr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Brooklyn Md

12 MAIDEN NAME OF MOTHER Josephine Kuehnle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mr. Harold E Geis Sr

(Address) 200 S. 3rd St

15 Filed 1 2 1927, 19 C. HAMPSON JONES, M. D. Registrar

By AKT

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 1927

17 I HEREBY CERTIFY, That I attended deceased from March 10th, 1927, to March 12th, 1927, that I last saw him alive on March 12th, 1927, and that death occurred, on the date stated above, at 11 30 a. m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Tom Leibel, M.D.

3/12, 1927 (Address) 1224-26 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL Mar. 12, 1927

20 UNDERTAKER John F. Denny — ADDRESS 715 Light

TION is very important See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20040

E 20040

## CERTIFICATE OF DEATH.

90

Registered No. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2912 Hartford Ave 9-15 St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julius A. Rose

(a) Residence No. 2912 Hartford Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. — mos. — ds. How long in U. S., if of foreign birth? 39 yrs. — mos. — ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-If single, ~~Married~~, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Marie Rose

6-DATE OF BIRTH (month, day and year) Aug 8th 1835

7-AGE, 91 yrs. 8 mos. 5 ds.

If LESS than 1 day, ....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Germany

PARENTS.

10-NAME OF FATHER, August Rose

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Frieda Nichol

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Germany

14- (Informant) Mr. Otto Rose

(Address) 2912 Hartford ave

15- MAR 13 1927 HAMPSON JONES, M. D. Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 11 27

17- I HEREBY CERTIFY, That I attended deceased from July 10, 1926, to March 11, 1927, that I last saw h in alive on March 8, 1927, and that death occurred, on the date stated above, at 12 15 a m.

The CAUSE OF DEATH* was as follows:

1 Arteriosclerosis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) J. Clark Fitzgerald M. D.

3/11/1927 (Address) 1623 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Emmanuel

DATE OF BURIAL, 3/14 1927

20-UNDERTAKER, L. Hearn and

ADDRESS L. Hearn & Bro

Instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20041

## CERTIFICATE OF DEATH.

66 / E 20041

1-PLACE OF DEATH

City of BALTIMORE: (No. 1104 E Lombard St., 3-5 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Bluzett

(a) RESIDENCE NO. 1104 E. Lombard St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F. | W. | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Bluzett

6 DATE OF BIRTH (month, day, and year) Not Known

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 40 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Not Known

(State or country) Lithuania

PARENTS

10 NAME OF FATHER Adam Lapinski

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Lithuania

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Lithuania

14 Informant Mrs Alice Eagles

(Address) 68 Hennerty Place, Balto

15 Filed ..... 19..... Registrar

By Magie.

APR 12 1926 HAMPSON JONES M. D.

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5 1926

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Alcoholism

(duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) — yrs. — mos. — ds.

M. D.

Mar 17 26 (Signed) Geo. Clinton Brack (Coroner)

(Address) 1432 E Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudown Park Date of Burial March 17 1926

20 UNDERTAKER John McWeber ADDRESS 1803 Bank St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20042

## CERTIFICATE OF DEATH.

90

E 20042

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4139 Old Pimlico Road (ST.) (WARD) 15

2-FULL NAME Flora A. Englar

(a) RESIDENCE NO 4139 Old Pimlico Road (ST.), WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Female | White | Widowed |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 29 - 1850

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 77 | — | 3 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Maryland

PARENTS

10 NAME OF FATHER John W. Ogburn

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliza Poll

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Mrs Ordella Dorsey
(Address) 4139 Pimlico Road

15 Filed APR 13 1927 C. HAMPSON JONES, M. D.
Per Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 12th 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Valvular disease of Heart

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) C. Hampson Jones, M. D.

3/13, 1927 (Address) 1632 Riverside

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Bethel

DATE OF BURIAL 3/15 1927

20 UNDERTAKER H Barkard & Son

ADDRESS Westminster Md

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificate.
TION is very important.

Spec.—12-9-25—A Co.—200 Bks.

20042

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20043

## CERTIFICATE OF DEATH.

117

E 20043

1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home & Infirmary St. 19 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret James

(a) RESIDENCE NO. Aberdeen, Md St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Cirrect 10th-1898

7 AGE: Years 28 | Months 7 | Days 2 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of indnstry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Harford Co. Md

PARENTS

10 NAME OF FATHER C. Harry James

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Harford Co. Md

12 MAIDEN NAME OF MOTHER Gertrude Mc Coy

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Harford Co. Md

14 Informant Mr. C. Harry James

(Address) Aberdeen Md. R.F.D.

Filed MAR 13 1927 H. [illegible] JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 19 27

17

I HEREBY CERTIFY, That I attended deceased from Dec. 30 19 26 to March 12 19 27.

that I last saw h.er alive on March 12, 19 27

and that death occurred, on the date stated above, at 2.55 P. m.

The CAUSE OF DEATH* was as follows:

Peritonitis

(Appendicitis, acute, ruptured, unoperated.)

(duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY

(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death? At Home Dec 30, 1926

Did an operation precede death? Yes Date of March 1, 1927

Was there an autopsy? No

What test confirmed diagnosis? Operations

(Signed) R. Clark Grove, M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Smith Chapel Cemetery Harford Co. Date of Burial: March 13 1927

20 UNDERTAKER: Henry Tanning Son ADDRESS: Aberdeen Md

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

2438 Eutaw Place

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20044

## CERTIFICATE OF DEATH.

90

E 20044

REGISTERED NO. 10-64

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2540 W. Lanvale ST. (or WARD) 20th

2-FULL NAME Anna H. Gieb

(a) RESIDENCE NO. 2540 W. Lanvale ST. 20th WARD

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. 11 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: August H. Gieb

6 DATE OF BIRTH (month, day, and year): March 26th 1863

7 AGE: Years 63 Months 11 Days 12 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (City or town) (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER: Peter Michael

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Margaret Rost

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Germany

14 Informant (Address): Aug H. Gieb 2540 W. Lanvale St.

15 Filed MAR 13 1927, 19 [illegible] Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 10th 1927

17

I HEREBY CERTIFY, That I attended deceased from January 1903 to March 10 1927.

that I last saw her alive on 10/20 27 A.M. 4/30 1927 P. m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Apoplexia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Myocarditis

(duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? X. Boggs

(Signed) A. K. A. Klopp M. D.

11th 14 1927 (Address) 2431 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery

DATE OF BURIAL: March 14 1927

20 UNDERTAKER: F. B. Keffler, 1534 N. Eden St.

ADDRESS

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20045

E 20045

## CERTIFICATE OF DEATH.

11-001

24-64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3510 Norwood ave ST. ) (WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles E. Sloan

(a) RESIDENCE. No. 3510 Norwood av ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos. ds

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 23, 1925

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 1 | 6 | 18 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) ~~Ohio~~ Balto Md.

PARENTS

10 NAME OF FATHER Charles E Sloan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland Ohio

12 MAIDEN NAME OF MOTHER Mary Wiley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Charles E Sloan

(Address) 3510 Norwood ave

FILED MAR 19 1927 C. HAMPSON Registrar M. D.

Per R.L.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 11 1927.

17

I HEREBY CERTIFY, That I attended deceased from Feb. 21, 1927, to March 11, 1927, that I last saw him alive on March 11, 1927, and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptomes

(Signed) Howard C. Sloan, M. D.

, 19 (Address) 3716 Liberty Heights ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Madonna, Harford Co Md | March 14, 1927 |
| 20 UNDERTAKER E. LeRoy Stiffler | ADDRESS 125 E North Ave |

TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20046
1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

129 E 20046
REGISTERED NO.

City of BALTIMORE: (No. Sinai Hospital St., 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lina Fried

(a) RESIDENCE NO. Sinai Hospital - Aged Home Ward

(Usual place of abode)

Length of residence in city or town where death occurred lifetime mos. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec. 11- 1858

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 68 | 3 | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country): Md.

PARENTS

10 NAME OF FATHER: Henry Fried

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Sophie Hetz

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Germany

14 Informant: Mrs. I. Leidenberg

(Address) 24 Callow Ave.

MAR 13 1927

Registered by H. P. JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/11/27 19

17

I HEREBY CERTIFY, That I attended deceased from ....., 19....., to 3/11/27, 19.....,

that I last saw h.. alive on 3/11/27, 19.....,

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBITORY (Secondary) C.V. Renal Disease

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. Krevsky, M. D.

, 19 (Address) Sinai Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship — Date of Burial: 3/13/1927

20 UNDERTAKER: David Sondheim — ADDRESS 1820 W. Mt Royal Ave.

For ...

(Instructions on back of certificates. Name, residence or place of death, color, sex, age, date of death, cause of death, name of undertaker, and date of burial are required. Physician's certificate of cause of death must be filed within 24 hours after death occurs. Undertaker's certificate of burial must be filed before burial. Registrar's certificate of burial must be filed before burial

Spec.—1-12-23—M&T—500 Bks.

Masbach

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20047

E 20047

## CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Baltimore Gen. Hosp. (St.) 5-63 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Masbach

(a) RESIDENCE NO. ~~2127 Calvert~~ 3704 Liberty ~~Eutaw~~ ~~WARD~~

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jeannette Masbach

6 DATE OF BIRTH (month, day, and year): Jan 5 1856

7 AGE: Years 71 | Months 2 | Days 7 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Nolden Masbach

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Emily Oppenheimer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): West Balt. Gen. Hosp.

15 Filed APR 13 1927 C. HAMPSON JONES M.D. Registrar

Per R.M.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/12 1927

17 I HEREBY CERTIFY, That I attended deceased from 11/24, 1927, to 3/12, 1927, that I last saw him alive on 3/12, 1927, and that death occurred, on the date stated above, at 6 11 p m.

The CAUSE OF DEATH* was as follows: Carcinoma of Stomach

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 3/10/27

Was there an autopsy? no

What test confirmed diagnosis? Clinical History

(Signed) Arnold L. Gerstenberger, M. D.

3/12 1927 Address West Baltimore Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Hebrew Cem.

DATE OF BURIAL: 3/14/1927

20 UNDERTAKER: David Sondheim

ADDRESS: 1150 W. Mt. Royal Ave.

THIS IS very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20048

## CERTIFICATE OF DEATH.

49

15-60

E 20048

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1801 N Smallwood ST. WARD)

2-FULL NAME Edith Maud Birch

(a) RESIDENCE NO. 1801 N Smallwood ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of or) WIFE of Divorced Sam Birch

6 DATE OF BIRTH (month, day, and year) Sept 23. 1865

| 7 AGE Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|
| 61 | 6 | 18 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co Md

PARENTS

10 NAME OF FATHER George W Scaggs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Montgomery Co Md

12 MAIDEN NAME OF MOTHER Mary S Naylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co Md

14 Informant Mrs Mary Wyatt

(Address) 432 N Smallwood

15 Filed MAR 3 1927 19. C. HAMPSON JONES, M. D. Registrar

By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct. 1926. to March 11. 1927.

that I last saw her alive on March 10. 1927.

and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Sarcoma of thigh bone

(duration) yrs. 7m 8 mos ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Fred B Jones, M. D.

19 (Address) 2576 Pennsylvania

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Woodlawn Cemetery | March 14 1927 |
| 20 UNDERTAKER | ADDRESS |
| Chas. G. Black & Co | 742 N. North ave |

TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

91-002

E 20049
1-PLACE OF DEATH

13-59

E 20049
REGISTERED NO.

City of BALTIMORE: (No. 750 Reservoir St. 13-59 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaretta Cooley

(a) RESIDENCE NO. 750 Reservoir St. Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. — mos. — ds. How long in U. S., if of foreign birth? 42 yrs. — mos. — ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | white | widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Henry Cooley

6 DATE OF BIRTH (month, day, and year) Sept 9 1850

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 76 | 6 | 2 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) England

PARENTS

10 NAME OF FATHER James Cottier

11 BIRTHPLACE OF FATHER (city or town)
(State or country) England

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Margaretta Constance Cooley
(Address) 750 Reservoir st.

Filed MAR 13 1927 C. HAMPSON JONES, M. D.
Registrar
Per RR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March - 11 - 27 19

17 I HEREBY CERTIFY, That I attended deceased from March - 1 1927, to March - 11, 1927 that I last saw h~~e~~ alive on March - 11, 1927 and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Hypertrophy of Heart, C
(duration) ...yrs. ...mos. 2 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 4 yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Martin A. Shook M. D.

3-12-1927 (Address) 806 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — Date of Burial: March 14 1927

20 UNDERTAKER: Chas. G. Black — ADDRESS: 742 W. North Ave

Copy of this certificate, duly certified by the proper registrar, will be required by undertaker before burial or removal of body. Read carefully the certificates, and if any of the questions are not applicable write "None." Every question should be answered, as the omission of any item may cause delay in issuing permit. Especially important. See instructions on back of certificate. Fill out with pen and ink. Write plainly. Use figures for dates. Do not abbreviate. Sign full name. Report of birth must be filed before certificate of death can be issued. Report of birth must be filed before certificate of death can be issued. Report of birth must be filed before certificate of death can be issued

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 20050

REGISTERED NO. E 20050

1-PLACE OF DEATH

City of BALTIMORE: (No. 317 E 24th St. St. 17-509 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nelson W. Swann

(a) RESIDENCE NO. 317 E 24th St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 4yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male. | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 31, 1926.

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min.. |
|---|---|---|---|---|
| | | 2 | 13 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) md.

(State or country)

PARENTS

10 NAME OF FATHER James N. Swann

11 BIRTHPLACE OF FATHER (City or town) md.

(State or country)

12 MAIDEN NAME OF MOTHER Stella E. Blaney

13 BIRTHPLACE OF MOTHER (city or town) md.

(State or country)

14 Informant James N. Swann

(Address) 317 E 24th St

15 Filed MAR 13 1927 19 C. HAMILTON JONES, M. D. Registrar

Per R.C.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12, 19 27.

17 I HEREBY CERTIFY, That I attended deceased from 3/9, 19 27, to 3/12, 19 27, that I last saw him alive on 3/12, 19 27, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia Organic

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Carroll Leon, M. D.

3/12 19 27 (Address) 713 N Washington

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Holy Cross Harford Co | March 13 27 |
| 20 UNDERTAKER | ADDRESS |
| Chenowith Son | 3417 Chestnut Ave |

(OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.)

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

101-001

E 20051 DEATH

REGISTERED NO. E 20051

City of BALTIMORE: (No. 612 S Fulton Ave St., 16-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Brosnan

(a) RESIDENCE NO. 612 S Fulton Ave St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 ~~Single, Married~~, Widowed, or ~~Divorced~~ (write the word): Widowed

5a If ~~married, widowed, or divorced~~ (or) WIFE of: Wm A Brosnan

6 DATE OF BIRTH (month, day, and year): Sept. 5th 1850

7 AGE: 76 Years 77 | Months 6 | Days 7 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: _____

(b) General nature of industry, business, or establishment in which employed (or employer): Housework

(c) Name of employer: _____

9 BIRTHPLACE (~~City or town~~): _____

(State or country) Baltimore

PARENTS

10 NAME OF FATHER: Golland

11 BIRTHPLACE OF FATHER (city or town): _____

(State or country) Baltimore

12 MAIDEN NAME OF MOTHER: Lenhenna

13 BIRTHPLACE OF MOTHER (city or town): _____

(State or country) Baltimore

14 Informant: Saddie Miller

(Address) 612 S Fulton Ave

15 Filed MAR 13 1927 C. HAMILTON JONES, M. D. Registrar

Per _____

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: 3/12/27

17 I HEREBY CERTIFY, That I attended deceased from 3/10/27 19..... to 3/12/27 19.....,

that I last saw h.. alive on 3/10/27, 19.....,

and that death occurred, on the date stated above, at 8:04 m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) Hrs yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) _____

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? — Date of _____

Was there an autopsy? —

What test confirmed diagnosis? _____

(Signed) Bernard Fenny, M. D.

3/13/1927 (Address) 910 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem — Date of Burial 3-14 1927

20 UNDERTAKER: Robert Brooks & Son — ADDRESS Baltimore Md

Be sure that every item is correctly answered. Cause of death in plain terms, so that it may be properly classified. Last Statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

Dr Culbertsons 1901 Eutaw Place

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 20052 9 E 20052

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 501 E 21st St. 9-19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J Shanahan Jr

(a) RESIDENCE NO. 501 E 21st St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred / yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 28, 1926

7 AGE: Years 8 Months Days 13 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Dal to (State or country) Md

PARENTS

10 NAME OF FATHER John J Shanahan

11 BIRTHPLACE OF FATHER (City or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rose Kerr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) John J Shanahan 501 E 21st St

Filed ..... 19 ..... C. HARRISON JONES, M. D. Registrar

Per .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Mch 7 1927 to Mch 11 1927

that I last saw him alive on Mch 11 1927

and that death occurred, on the date stated above, at 9.45 P m.

The CAUSE OF DEATH* was as follows:

Bronchio - Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Whooping Cough ?

(duration) yrs. mos. 7 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical diagnosis

(Signed) C H Culbertson, M. D.

3/13 1927 (Address) 1901 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Johns, Long Green, Md.

Date of Burial: Mch 14 1927

UNDERTAKER

ADDRESS 502 E North Ave

MAR 13 1927

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

Drawn 1227 Hartsdale ✓

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20053

99-002 E 20053

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1716 McHenry St., Ward 19-28)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Mullen

(a) RESIDENCE NO. 1716 McHenry St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles X Mullen

6 DATE OF BIRTH (month, day, and year): Sept 18 1839

7 AGE — Years: 87 Months: 5 Days: 23 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER: Gottlieb Austin

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Liz Austin

13 BIRTHPLACE OF MOTHER (City or town):

(State or country): Germany

14 Informant: Ernst E. Gordon

(Address): Munsey Bldg.

15 Filed MAY 3 1927, 19.. C. HAMPSON JONES, M. D. Registrar

Pay

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 12 1927

17 I HEREBY CERTIFY, That I attended deceased from 1-5, 1927 to 3-12-, 1927

that I last saw her alive on 3-12-, 1927

and that death occurred, on the data stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Oedema of Lungs

(duration) 2 yrs. mos. 15 ds.

CONTRIBUTORY (Secondary): Senile Dementia

(duration) 3 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Data of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Theodore Brann, M. D.

, 19 (Address) 1717 Mosher

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dan Cathedral — Date of Burial: May 14 1927

UNDERTAKER: J. H. Cook — ADDRESS: 500 E. North Ave

Of Death in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Dr Smith 4706 Harford Rd

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE.

E 20054

## CERTIFICATE OF DEATH

100-001 E 20054

1-PLACE OF DEATH

REGISTERED NO. 23-31

City of BALTIMORE: (No.) 300 N Hamilton Ave (St.) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha E Greene

(a) RESIDENCE NO. 300 N Hamilton Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | W | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John T Greene

6 DATE OF BIRTH (month, day, and year) May 22, 1851

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 75 | 9 | 14 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Henry Bohner

11 BIRTHPLACE OF FATHER (City or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Kate Durbank

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Laura Lawson

(Address) 300 N Hamilton Ave

15 Filed MAR 13 1927 C. HAMPSON JONES, M. D. Registrar

Par RR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 7, 1927 to Mar 11, 1927

that I last saw h alive on Mar 11, 1927

and that death occurred, on the data stated above, at m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis & Bronchitis

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

3/12 1927 (Address) 4 W Lexington St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parrells ville, Md Date of Burial Mar 14 1927

20 UNDERTAKER W. A. Cook ADDRESS 501 Ellwood Ave

very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20055

E 20055

## CERTIFICATE OF DEATH

31

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No.) 349 West 21st St. (Ward) 17-51

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas A. Welsh

(a) RESIDENCE NO. 349 West 21st St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 22-1900

7 AGE: Years 26 Months 10 Days 10

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Chauffer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Bryant & Co

9 BIRTHPLACE (city or town)

(State or country) Balto Md

PARENTS

10 NAME OF FATHER Michael Welsh

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary Cornelius

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto Md

14 Informant Thos Welsh

(Address) 349 West 21st

15 Filed MAR 13 1927 C. HAMILTON JONES, M. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 27

Mch 12

17 I HEREBY CERTIFY, That I attended deceased from Mch 10, 1927, to Mch 12, 1927, that I last saw h[illegible] alive on Mch 11, 1927, and that death occurred, on the date stated above, at 12-20 P.M.

The CAUSE OF DEATH was as follows: Chronic Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis Acute

(duration) [illegible] yrs. mos. ds.

18 Where was disease contracted Baltimore

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam & Clinical

(Signed) W. R. Murray M. D.

, 19 (Address) 1439 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters Cemetery

Date of Burial 3-15 1927

UNDERTAKER Wm Cook

ADDRESS 502 W Lafayette

Or PAGE IS PRINTED ON, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Dr Braun 1227 York Blvd

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20056

## CERTIFICATE OF DEATH

11-001 E 20056

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1212 Glyndon Ave St. 21-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick W. Wehrenberg

(a) RESIDENCE NO. 1212 Glyndon St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Wehrenberg

6 DATE OF BIRTH (month, day, and year) Nov 25, 1852

| 7 AGE | Years | Months | Days | IF LESS than 1 day ...hrs. or ...min.. |
|---|---|---|---|---|
| | 74 | 3 | 16 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Box Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Bath Tube Co

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs Mary Stein

(Address) 1829 W Mulberry St

MAR 13 1927

C. HARRISON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11 1927

17 I HEREBY CERTIFY, That I attended deceased from 3-4- 1927 to 3-11- 1927

that I last saw him alive on 3-11- 1927

and that death occurred, on the date stated above, at 4 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 1 yrs. 3 mos. 7 ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. mos. 15 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Mayfield Davis M. D.

, 19 (Address) 1227 Med. Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park, Violetville — Date of Burial Nov 14 1927

20 UNDERTAKER J. W. Cook — ADDRESS 502 Park Ave

very important. See instructions on back of certificate. Each statement of OCCUPATION is

Spec.–7-17-26—A Co.—200 Bks.

2605 – Blair Rd.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20057

## CERTIFICATE OF DEATH

E 20057

90

1-PLACE OF DEATH

near Bachmer Gun

REGISTERED NO. 76-40

City of BALTIMORE: (No. Lowys Lane St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward H. Jordan

(a) RESIDENCE NO. Lowys Lane St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Wh | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Melissa

6 DATE OF BIRTH (month, day, and year) April 19- 1854

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 72 | 10 | 22 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer 030

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer Everadem

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Zachariah Jordan

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Mc Kown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Melissa Jordan

(Address) Lowys Lane

Filed MAR 13 1927 H. HARRISON JONES, M. D. Registrar

By RR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch. 11 - 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 26, 1927, to Mar 11, 1927, that I last saw him alive on Mar 10, 1927, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows: Acute Cardiac Dilitation

Chronic Myocarditis

(duration) 2 yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilitation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Examination

(Signed) E. H. Rosoly M. D.

, 19 (Address) 617 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakland Mch. Date of Burial Mch 14 1927

UNDERTAKER J. M. Cole

ADDRESS 502 E. Baltimore

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 20058 — 185 — E 20058

1 PLACE OF DEATH Franklin Square Hospital

CITY OF BALTIMORE: (No. Fayette & Calhoun Sts. 22-30 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Martha E. Swan

(a) RESIDENCE NO. 312 Emory St. ST.; WARD
(Usual place of abode)
Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed or Divorced, (write the word) |
|---|---|---|
| F | W | married |

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Benjamin Swan

6 DATE OF BIRTH (month, day, and year) 1858

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or min. |
|---|---|---|---|---|
| | 68 | | | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Norfolk Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Harry B Pratt
(Address) 628 Portland St

15 Filed MAR 13 1927, 19.. Per R.H.C. C. HAMILTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/11 1927.

17 I HEREBY CERTIFY, That I attended deceased from 2/14/ 1927, to 3-11- 1927.
that I last saw her alive on 3/11 1927.
and that death occurred, on the date stated above, at 8 45 P. m.

18 The CAUSE OF DEATH* was as follows:
Fractured neck of Femur

2/14/27 (duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia
3/5/27 (duration) 3/11/27 mos. ds.

Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) W Warren Walker M. D.
, 19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Mar 14 1927

UNDERTAKER H. M. Cook — ADDRESS 502 E Monument

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

Dr Hennessy

# HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

117 E 20059

E 20059

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hospital St. 26-39 Ward)

2-FULL NAME Dorothy M. C. Martin

(a) RESIDENCE NO. 3334 E. Baltimore St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | W | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 6. 1914

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 12 | 3 | 4 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School Girl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Ohio

PARENTS

10 NAME OF FATHER Charles F. Martin

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va.

12 MAIDEN NAME OF MOTHER Irene M. C. Grune

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ill.

14 Informant Charles F. Martin
(Address) 3331 E Baltimore St

15 Filed MAR 13 1927 C. HAMILTON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

appendicitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Ruptured appendix

(duration) yrs. mos. 1 ds.

(Signed) J. T. Hennessy M. D. (Coroner)

March 11, 1927 (Address) 1802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Date of Burial March 13 1927

20 UNDERTAKER Fulton Cook ADDRESS 502 E Baltimore

very important. See instructions on back of certificate.

Dr Strachey 632 Forrest

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20060

E 20060

90

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 407 E 31st St. 12-5D Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H Ely

(a) RESIDENCE NO. 407 E 31st St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah J Ely

6 DATE OF BIRTH (month, day, and year): March 21, 1844

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min.. |
|---|---|---|---|---|
| | 82 | 11 | 20 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Garret Ely

11 BIRTHPLACE OF FATHER (City or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Eliz. Burnett

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Md

14 Informant (Address): Sarah J Ely 407 E 31st St

15 Filed ..... 19 ..... C. HAMILTON JONES, M. D. Registrar

Per .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 5, 1927, to March 11, 1927, that I last saw him alive on March 11, 1927, and that death occurred, on the date stated above, at 5.15 P m.

The CAUSE OF DEATH* was as follows:

Paralysis + mitral systolic murmur, with hypertrophy.

(duration) 1 yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) H H Strachey, M. D.

612 Address

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery Date of Burial: March 14 1927

20 UNDERTAKER: H. P. Cook ADDRESS: 501 E Monument

Oil Cloth in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

E 20061

# HEALTH DEPARTMENT--CITY OF BALTIMORE

E 20061

## CERTIFICATE OF DEATH

90

REGISTERED No. C

1 PLACE OF DEATH
6000 York Road
CITY OF BALTIMORE (No. Govans St.: Balto City WARD) 27-48

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Ida Elizabeth Brown

(Residence in Baltimore: No. 6000 York Rd. Govans St.: 9 yrs. mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: June (Month) 25 (Day), 1865 (Year)

7 AGE: 61 yrs. 8 mos. 15 ds. If LESS than 1 day, hrs. or min.? 17

8 OCCUPATION
(a) Trade, profession, or particular kind of work: School Teacher
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Balto Co

PARENTS

10 NAME OF FATHER: Ezra Fell Brown

11 BIRTHPLACE OF FATHER (State or country): Howard Co.

12 MAIDEN NAME OF MOTHER: Elizabeth Dunphy

13 BIRTHPLACE OF MOTHER (State or country): Towson

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Emma K. Dunphy
(Address) Bosley ave Towson

15 Filed MAR 19 1927, 191
C. HAMPSON JONES, M. D.
By K H REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: March (Month) 12 (Day), 1927 (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 22, 1926, to Mar 12 1927.
that I saw her alive on March 11, 1927.
and that death occurred, on the date stated above, at 11 A m.
The CAUSE OF DEATH* was as follows:
Bacterial Endocarditis

(Duration) yrs. mos. 2 1 ds

Contributory (SECONDARY) Embolism, Renal, Cerebral

pulmonary cardiac (Duration) yrs. mos. 3 ds.

(Signed) Chas C W Judd M. D.
Mar 12, 1927 (Address) 222 Wendom Road

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Prospect Hill Cem. DATE OF BURIAL: March 16, 1927

20 UNDERTAKER: John Burns Son ADDRESS: Towson Md

(Fill in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.)

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20062

## CERTIFICATE OF DEATH.

129 E 20062

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1206 St. Mathew ST. 5-8 WARD)

2-FULL NAME Morris Feldman

(a) RESIDENCE NO. 1206 St. Mathew ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hetta Feldman

6 DATE OF BIRTH (month, day, and year) Unknown.

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 64 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Peddler

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Ruben Feldman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Frah—

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Hetta Feldman

(Address) 1206 St. Mathew

15 Filed ..., 19 ... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-13-1927

17

I HEREBY CERTIFY, That I attended deceased from March 11, 1927, to March 13, 1927, that I last saw him alive on March 13, 1927, and that death occurred, on the date stated above, at 9 20 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, Chron. Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Hemoplegia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W J Baylin, M. D.

3/13, 1927 (Address) 210 S. Paca

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale — DATE OF BURIAL: 3-19-1927

20 UNDERTAKER: Jack Levin — ADDRESS: 1471 E Balto

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20063

## CERTIFICATE OF DEATH.

49

E 20063

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Maryland Gen'l Hosp. ST. 23-33 (WARD)

2-FULL NAME Miss Anita Gold Bloom

(a) RESIDENCE No. 913 S. Charles St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11-10-1903

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 23 | 4 | 3 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Morris Gold Bloom

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Sara Street

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Hospital Records (Address)

15 Filed APR 3 1927 19 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-13 1927

17 I HEREBY CERTIFY, That I attended deceased from 3-1 1927 to 3-13 1927.

that I last saw her alive on 3-13 1927,

and that death occurred, on the date stated above, at 4.45 Am.

The CAUSE OF DEATH* was as follows:

Cerebral tumor

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Coma due to cerebral pressure (duration) yrs. mos. 2 days?

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) E. S. Zimmerman M. D.

19 (Address) Md. Gen'l Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

16 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Rm

DATE OF BURIAL: Apr 19 27

20 UNDERTAKER: Jack Lewis

ADDRESS: 1839 Druid

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

Buckner

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20064

## CERTIFICATE OF DEATH.

100-001

E 20064

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2213 Westwood Ave ST. 16-68 WARD)

2-FULL NAME Rebecca Buckner

(a) RESIDENCE NO. 2213 Westwood ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5yr yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 13-1926

7 AGE: Years | Months 5 | Days 29 | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work [illegible]

(b) General nature of industry, business, or establishment in which employed (or employer) Child

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Harry Buckner

11 BIRTHPLACE OF FATHER (city or town) (State or country) POLAND

12 MAIDEN NAME OF MOTHER Katie Silver

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Harry Buckner

(Address) 2213 Westwood Ave

15 Filed MAR 13 1927 C. HARRY JONES, M. D. Registrar

Per

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar. 1 , 19 27 , to Mar. 12 , 19 27 ,

that I last saw h[illegible] alive on Mar. 12 , 19 27

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of -

Was there an autopsy? -

What test confirmed diagnosis? Clinically

(Signed) [illegible] M. D.

, 19 (Address) 11 E. Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rest Lawn

DATE OF BURIAL: 3/15 19 27

20 UNDERTAKER: Jacob Lewis

ADDRESS: 1489 Block

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20065

## CERTIFICATE OF DEATH. 100-001

REGISTERED NO. E 20065

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2448 Callow Ave ST., 12 59 WARD)

2-FULL NAME Sarah Klein

(a) RESIDENCE No. 2448 Callow Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ~~Life~~ 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Samuel Klein

6 DATE OF BIRTH (month, day, and year): Dec 16 1851

7 AGE: Years 75 Months 2 Days 24 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Hagerstown Md

PARENTS

10 NAME OF FATHER: David Stern

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Fanny Exel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Morris Klein

(Address): 2448 Callow Ave

15 Filed MAR 14 1927, 19 C. HAMPTON JONES, M. D. Registrar

By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 12 1927

17 I HEREBY CERTIFY, That I attended deceased from Monday, 19 27, to March 12 19 27, that I last saw her alive on March 12, 19 27 and that death occurred, on the date stated above, at 11:30 m

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary): Senile Pul Edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Emil F. Zeigler, M. D.

3/13, 1927 (Address) 1501 E. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship

DATE OF BURIAL: March 14 19 27

20 UNDERTAKER: Jack Lewis

ADDRESS: 1429 E. Eutaw

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 20066 — 1-PLACE OF DEATH

90

E 20066 — REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1407 E Clement ST. 24-33 WARD)

2-FULL NAME Henrietta Schlordt

(a) RESIDENCE NO. 1407 E Clement ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow. |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Karl Schlordt

6 DATE OF BIRTH (month, day, and year) April 14-1846

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 80 | 10 | 26 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER John Gast

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs Kramer

(Address) 1407 E Clement

15 Filed MAR 13 1927 19 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1927

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1926, to March 10, 1927.

that I last saw he alive on March 9, 1927.

and that death occurred, on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Accompanies Mitral Regurgitation

(duration) 1 yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? None

(Signed) Chas S. A. Burns, M. D.

3/11, 1927 (Address) 2528 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cem

UNDERTAKER J. Fenn McCurdy

DATE OF BURIAL 3/14 1927

ADDRESS 130 E Fort

THIS IS very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 20067 HEALTH DEPARTMENT—CITY OF BALTIMORE E 20067

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Maryland Gen'l Hospital (St.) 11-24 (Ward)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Shakespeare

(a) RESIDENCE No. 26 Township Road, Hunsdale, WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs mos 10 ds How long in U. S., if of foreign birth? yrs mos ds

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9-5-1909

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 17 | 6 | 5 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Morgantown
(State or country) West Virginia

PARENTS

10 NAME OF FATHER Nehiel Shakespeare

11 BIRTHPLACE OF FATHER (city or town)
(State or country) England

12 MAIDEN NAME OF MOTHER Marguerite Weaver

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) England

14 Informant Hosp. Records
(Address)

15 Filed JAN 13 1927 C. HALLOCK JONES, M. D. Registrar
Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-10 1927

17 I HEREBY CERTIFY, That I attended deceased from 2-20 1921 to 3-10 1927.
that I last saw her alive on 3-10 1927.
and that death occurred, on the date stated above, at 9:45 A. m.

The CAUSE OF DEATH* was as follows:
Toxic adenoma thyroid
about 6 weeks (duration) yrs. mos ds.
CONTRIBUTORY (Secondary) Myocarditis - Co
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of 3-7-27
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) C. C. Zimmerman M. D.
19 (Address) Md. Gen'l Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem — DATE OF BURIAL 3/14 1927

20 UNDERTAKER J. Fen McCully — ADDRESS 130 E Fort

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20068

## CERTIFICATE OF DEATH.

188-001 E 20068

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1212 S Paca St. 21-24 Ward

2-FULL NAME Richard Fraumer

(a) RESIDENCE NO. 1212 S Paca St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna E Fraumer

6 DATE OF BIRTH (month, day, and year): June 3 1874

7 AGE: Years 52 Months 9 Days 8 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter

(b) General nature of industry, business, or establishment in which employed (or employer): Paint

(c) Name of employer

9 BIRTHPLACE (city or town): Germany

(State or country)

PARENTS

10 NAME OF FATHER: not known

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: not known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: Anna E Fraumer

(Address) 1212 S Paca St.

Filed 19 HAROLD JONES M Registrar

R 13 1927 Rec'd K M

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/11/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Railroad accident
Shock & laceration
Scalp & F.

Trauma (duration) yrs. Pr mos. ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis (duration) yrs. 1 mos. ds.

(Signed) Samuel Hughes M. D.
(Coroner)

, 19 27 (Address) 325 Patapsco

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

Date of Burial: March 14 1927

20 UNDERTAKER: Robt J Lucas Inc

ADDRESS 1401 N Broadway

very important. See instructions on back of certificate.

Spec. 7-17-26—A Co.—200 Blks.

E 20069

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20069

## CERTIFICATE OF DEATH

105

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 217 S. Bond St. St. 3-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Sirens

(a) RESIDENCE NO. 217 S. Bond St. Ward

(Usual place of abode) Lifetime

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widower |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Sirens

6 DATE OF BIRTH (month, day, and year) Unknown 1867

7 AGE Years About 60 Months Days IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Michael Sirens

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mrs. Mutshill

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Edward Sirens

(Address) 217 S. Bond St.

15 Filed MAR 13 1927 C. HARTMAN JONES, M. D. Registrar

Per RM

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 March 12th. 1927.

17 I HEREBY CERTIFY, That I attended deceased from 1/15 . 1927. to 3/12 . 1927.

that I last saw h alive on 3/11 . 1927.

and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Bronchial asthma

Cardiac Dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no What test confirmed diagnosis? by symptoms

(Signed) Resident M. D.

. 19 27 (Address) 3325 Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Peters Cemetery. Date of Burial 3/15 1927

20 UNDERTAKER Chas. P. Evans & Son ADDRESS 1181 North Royal Ave

very important. See instructions on back of certificates.

R 13 1927

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

19763 — E 20070 — 84 — E 20070

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 7-9 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mathan Saloff

(a) RESIDENCE NO. Pompton Lake N. J. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Saloff

6 DATE OF BIRTH (month, day, and year) unknown.

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 47 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Russia

(State or country)

PARENTS

10 NAME OF FATHER Morris Saloff

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed APR 13 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

March 13-1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 31 1927, to March 13, 1927, that I last saw him alive on March 13, 1927, and that death occurred, on the date stated above, at 6.15 P.m.

The CAUSE OF DEATH was as follows:

(Sanger)

Brain tumor, Meningitis after operative removal of tumor

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Meningitis, bronchopneumonia

(duration) — yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death? Pompton Lake, N.J.

Did an operation precede death? yes Date of 2.3.27.

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) George S. Jamney, M. D.

Mar 13 1927 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

new York city n.y. 3/13 1927

20 UNDERTAKER — ADDRESS

Jack Levin 1402 E. Baltimore

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20071

## CERTIFICATE OF DEATH. 161-001 E 20071

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2020 Druid Hill Ave ST. 14-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Stewart

(a) RESIDENCE No. 2020 Druid Hill Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 9-27

7 AGE: Years | Months | Days | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Theodore Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Bessie Reynolds

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs Bessie Reynolds

(Address): 2020 Druid Hill Ave

15 Filed MAY 3 1927, 19 C. HAMPTON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mch 9 1927

17 I HEREBY CERTIFY, That I attended deceased from Mch 9, 1927, to Mch 9, 1927, that I last saw h[illegible] alive on Mch 9, 1927, and that death occurred, on the date stated above, at 12-28 m.

The CAUSE OF DEATH* was as follows:

Premature Baby

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) C. W. Kanzer, M. D.

, 19 (Address) 1521 E. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: 5/13 19 27

20 UNDERTAKER: Samuel Rainsberg

ADDRESS 537 N Eutaw

Spec.–7-17-26—A Co.—200 Bks.

E 20072

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20072

## CERTIFICATE OF DEATH

129

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 755 Eislen St. 12-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mamie Dickerson

(a) RESIDENCE NO. 755 Eislen St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | Colored | widowed |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1879

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min.. |
|---|---|---|---|---|
| | 48 yrs | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md

PARENTS

10 NAME OF FATHER John T Edgerly

11 BIRTHPLACE OF FATHER (City or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Woodley

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Viola Dorsette

(Address) 755 Eislen St

15 FILED APR 13 1927 C. HAMPTON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11th 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec. 10, 1926 to March 10, 1927

that I last saw h[illegible] alive on March 10, 1927

and that death occurred, on the date stated above, at 10:00 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY Chronic Interstitial Nephritis

(Secondary)

(duration) yrs. 3 mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John L Kleinschmidt M. D.

3/13, 1927 (Address) 624 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Mt Auburn Cemetery 3/11 1927

20 UNDERTAKER

Geo H Hooper & Company

ADDRESS 406 at

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

20073

# HEALTH DEPARTMENT—CITY OF BALTIMORE

620073. 11-001 620073.

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 511 Cording Ave ST. 2745 WARD)

2-FULL NAME Margaret Ellen League

(a) RESIDENCE NO. 511 Cording Ave. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widowed. |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George League

6 DATE OF BIRTH (month, day, and year) March 16 1857

| 7 AGE | Years | Months | Days | If LESS than 1 day, ...hrs. or ... min. |
|---|---|---|---|---|
| | 69 | 11 | 27 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ellas Md

PARENTS

10 NAME OF FATHER Mr. Hogue

11 BIRTHPLACE OF FATHER (city or town) Ellas (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Ellas Md (State or country)

14 Informant Mrs Laura M Young (Address) 26 So. Fremont St

15 Filed MAR 3 1927 C. HARRY JONES, M. Registrar

By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 5 1927 to Mar 13 1927.

that I last saw her alive on Mar 12 1927.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pluro Pneumonia

(duration) yrs. 8 mos 8 days ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. 8 mos. 8 days ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas E Saulsbury M. D.

3/3. 1927 (Address) Towson Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL Mar 16 1927

20 UNDERTAKER Ralph B Cook

ADDRESS 1003 W Fay

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

20074.

**E 20074**

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

15-64 170

**E 20074**

REGISTERED NO.

City of BALTIMORE: (No. 4017 Liberty Heights Ave 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John William Kempel

(a) RESIDENCE NO. 4017 Liberty Heights Avenue Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary G. Kempel

6 DATE OF BIRTH (month, day, and year) February 12, 1874

| 7 AGE | Years | Months | Days 24 | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 53 | 0 | 27 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) Self 050

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER John William Kempel

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhelmina (Unknown)

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs. Mary G. Kempel

(Address) 4015 Liberty Heights Ave.

15 Filed MAR 13 1927 C. HAMILTON JONES, M. D. Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) March 11, 1927 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by gunshot wound of head (revolver)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) E. T. Hammond M. D. (Coroner)

3-11-1927 (Address) 2802 Edmondson Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem Date of Burial Mar. 14, 27

20 UNDERTAKER Joseph D. Cook ADDRESS 1003 Pratt St

very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 20075 ✓ 20075

118-001

E 20075

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2142 Walbrook Ave. St. 15-68 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Coleman

(a) RESIDENCE NO. 2142 Walbrook Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William H. Coleman

6 DATE OF BIRTH (month, day, and year) January 12, 1868

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min.. |
|---|---|---|---|---|
| | 59 | 2 | xxx | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Patrick Mackin

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine (Unknown)

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Miss Mollie L. Coleman

(Address) 2142 Walbrook Ave.

15 Filed MAR 3 1927 Per R. Hampton Jones M. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

March 12, 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 7, 1927, to Mar 12, 1927.

that I last saw h er alive on Mar 12, 1927.

and that death occurred, on the date stated above, at 12 Noon m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Operation for Strangulation of abdominal Hernia

(duration) yrs. 1 mos ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of Feb 10/27

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) E Mules Wheeler M. D.

3-12 1927 (Address) 2129 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Mt. Olivet Cemetery | Mar. 15 1927 |
| 20 UNDERTAKER D. Joseph Cook | ADDRESS 1003 Park Ave |

very important. See instructions on back of certificates.

E 20076

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E.20076

## CERTIFICATE OF DEATH.

113

REGISTERED No. C

1-PLACE OF DEATH 722. Singer Ave.

CITY OF BALTIMORE (No. 722. Singer Ave. St.; 13-51 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen Luccia Eckert.

(Residence in Baltimore: No. 722. Singer Ave. St.; yrs. 0 mos. 2 ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

| 3-SEX | 4-COLOR OR RACE, | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.) |
|---|---|---|
| female. | white. | Baby. |

6-DATE OF BIRTH, December 27., 1926.
(Month) (Day) (Year)

7-AGE, 0 yrs. 2 mos. 15 ds. If LESS than 1 day, ....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... baby
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore City. Maryland.

PARENTS.

10-NAME OF FATHER, Joseph Clinton Eckert.

11-BIRTHPLACE OF FATHER (State or Country), Phoenix. Maryland.

12-MAIDEN NAME OF MOTHER Mary M. Cross.

13-BIRTHPLACE OF MOTHER (State or Country), Chestnut Ridge. Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary M. Eckert. (Mother).

(Address) 722. Singer Ave.

15- Filed 1 3 1927 C. HARRISON JONES, M. D. Registrar.

Per

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March. 12. th. 1927. 191
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

(a) Marasmus

.....

.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

..... (Duration).....yrs.....mos.....ds.

(Signed) ..... M. D. (Coroner.)

3/12/27, 191.. (Address) 3832. Roland Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St. Marys cem. Hampden.

DATE OF BURIAL, March. 14. 19. 27.

20-UNDERTAKER J. Walter Davis.

ADDRESS 3307. Maine St.

Spec.—12-9-25—A Co.—200 Bks.

E. 20077

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E. 20077.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO. 27-3090

City of BALTIMORE: (No. [redacted] St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John C. Holman

(a) RESIDENCE NO. 600 West Barre St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry M. Holman

6 DATE OF BIRTH (month, day, and year) July 4 1874

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 52 | 8 | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron Worker

(b) General nature of Industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Henry M. Holman

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Helen Murphy

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant [redacted] (Address) [redacted]

15 Filed MAR 14 1927, 19 C. HALL-KEY JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11 1927

17 I HEREBY CERTIFY, That I attended deceased from March 5 1927, to March 11, 1927, that I last saw him alive on March 11, 1927, and that death occurred, on the date stated above, at 5.45 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis 2 Bronchopneumonia

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? General & Laboratory

(Signed) R. Hooper Lamb, M. D.

Mch 12 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery Date of Burial 3/14 1927

20 UNDERTAKER E. J. Running Lic. 1938 ADDRESS Lafayette Ave.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20078

67-002

## CERTIFICATE OF DEATH.

REGISTERED NO. E 20078

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST. 24-35 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John G. Kuhn

(a) RESIDENCE No. 1435 Woodall ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs Elizabeth Kuhn

6 DATE OF BIRTH (month, day, and year): Nov. 25th 1855

7 AGE: Years 71 Months 3 Days 13 15 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Compound Mixer at Wheat Package Corp Plant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: not given

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: not given

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. Elizabeth Kuhn (Address) 1435 Woodall St

15 Filed APR 14 1927 C. HAMPTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3-10 1927

17 I HEREBY CERTIFY, That I attended deceased from 3-8 .1927. to 3-10 .1927. that I last saw h[illegible] alive on 3-10 .1927. and that death occurred, on the date stated above, at 6 06 P m.

The CAUSE OF DEATH* was as follows:

Benzol Poisoning, said he have had previous attack 10 yrs ago.

(duration) yrs. mos 2 ds

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical & Lab

(Signed) W P Mc Brady M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: March 14 1927

20 UNDERTAKER: Kelly & Zeiler — ADDRESS: 4038 Wolfe St

Cor.—12-9-25—A Co.—200 Bks.

E. 20079

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

11-001 ✓

REGISTERED No. E 20079

1-PLACE OF DEATH

City of BALTIMORE: (No. 3307 Clinton Ct St. 16-1 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Magdalene V. Huber

(a) RESIDENCE NO. 3307 Clinton Ct St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 1 1926

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | | 4 | 12 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto city

(State or country)

PARENTS

10 NAME OF FATHER Daniel Huber

11 BIRTHPLACE OF FATHER (city or town) Balto city

(State or country)

12 MAIDEN NAME OF MOTHER Anna Stangler

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto city

14 Informant Daniel Huber

(Address) 3307 Clinton Ct.

15 Filed ... 19 ... Registrar

APR 4 1927 per RL

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 1 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows: Bronchopneumonia

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) probably influenza

(duration) ... yrs. ... mos. ... ds.

(Signed) James M Fenlon M. D.

(Coroner)

3 12 1927 (Address) 708 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Mt. Carmel Cem. | Mch 4 1927 |
| **20 UNDERTAKER** | **ADDRESS** |
| Zirkler & Zirkler | 1739 E Eager St |

Spec.—1-12-23—M&T—500 Blks.

# E 20080 HEALTH DEPARTMENT—CITY OF BALTIMORE E 20080

## CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1131 S. Clinton St. 26-1 (WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John A. Selig

(a) RESIDENCE No. 1131 S. Clinton St. ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Divorced |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Christena Selig

6 DATE OF BIRTH (month, day, and year) Dec. 24-1843.

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs or ... min. |
|---|---|---|---|---|
| | 83 | 2 | 16 18 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Dora Schwartz
(Address) 1131 S. Clinton St

15 Filed R 14 1927 C. HARRISON JONES, M. D. Registrar
Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 1927

17 I HEREBY CERTIFY, That I attended deceased from December 10, 1926, to March 12, 1927, that I last saw him alive on March 11, 1927 and that death occurred, on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Appendicitis

(duration) 12 yrs. 2 mos.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) Unknown

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) Jos. A. Rosenblatt, M. D.

3/12, 1927 (Address) 3018 O'Donnell St, Balto, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Mt. Carmel Cem. | March 14 1927 |
| 20 UNDERTAKER Zirkler & Zirkler | ADDRESS 1739 E. Eager St. |

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

## CERTIFICATE OF DEATH

20081 PLACE OF DEATH Balto City Hospls. 25-72 REGISTERED NO. E 20081

City of BALTIMORE: (No. Balto Md St. 25-72 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Bartholow.

(a) RESIDENCE NO. 2255 Washington Boulevard

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? ? 1889

7 AGE: Years 37 | Months ? | Days ? | IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Painter

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Gardner Bartholow

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Emma Wilson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Balto City Hospls

(Address) Balto Md

15 Filed ... 19 ... Registrar

R 14 1927 E

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-11 1927

17 I HEREBY CERTIFY, That I attended deceased from 3-1, 1927 to 3-11, 1927

that I last saw him alive on 3-10, 1927

and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac failure - Terminal

Broncho Pneumonia

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Involutional Melancholia

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical findings

(Signed) Harry Goldsmith, M. D.

3/11 1927 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Date of Burial 3/13/27

UNDERTAKER Harry H. Deitzler ADDRESS 1031 W Fayette

Cor.—12-9-25—A Co.—200 Bks.

20082

# HEALTH DEPARTMENT—CITY OF BALTIMORE

×57 E 20082

## CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. Gen. Hosp. St. 11-24 Ward)

2-FULL NAME John D. Fryer

(a) RESIDENCE NO. James Tunnel Fire St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | married |

5a If married, widowed, or Divorced HUSBAND of (or) WIFE of Mary Fryer

6 DATE OF BIRTH (month, day, and year) about 1857

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 70 | | 20 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brakesman

(b) General nature of Industry, business, or establishment in which employed (or employer) Bethlehem Steel Co

(c) Name of employer Sparrows Point Md

9 BIRTHPLACE (city or town) Mt. Crawford Va

(State or country)

PARENTS

10 NAME OF FATHER Henry L. Fryer

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Scotland

12 MAIDEN NAME OF MOTHER Sally Lauderback

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) W. Va.

14 Informant Mrs. Geo. Hosp

(Address) Baltimore Md

15 Filed ..... 19 .....

C. THOMPSON JONES, M. D.

Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cellulitis of left arm (Struck arm against pipe)

(Accidental) (duration) yrs. 1 mos. 11 ds.

CONTRIBUTORY Diabetis

(Secondary)

(duration) unknown yrs. mos. ds.

(Signed) J. T. Hennessy M. D.

(Coroner)

1927 (Address) 2807 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Date of Burial 3/13/27

20 UNDERTAKER Harry A Witzke ADDRESS 1521 W Lombard

MAR 14 1927

Spec.—1-12-23—M&T—500 Blks.

E 20083 HEALTH DEPARTMENT—CITY OF BALTIMORE 40 E 20083

CERTIFICATE OF DEATH.

22-30

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 533 South Paca ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME SAVERIO GUGLIELMINI

(a) RESIDENCE No. 533 S Paca ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | Merried |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) AUG. 24. 1852

| 7 AGE | 74 Years | 6 Months | 19 Days | If LESS than 1 day, hrs or min |
|---|---|---|---|---|

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work No.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Salvatore Guglielmini

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Jose. Biaucatte

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Mr Jefe
(Address) 533 S Paca St.

15 Filed APR 14 1927 H. HARRISON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/13.1927 19

17 I HEREBY CERTIFY, That I attended deceased from Mar 12. 19 27, to 19, that I last saw him alive on Mar. 02. 19 27 and that death occurred, on the date stated above, at 2. A m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular heart disease.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac paralysis.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical examination

(Signed) Dr. V. Culotta M. D.

, 19 (Address) 811. 20th. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Holy Redeemer | March 14.1927 |

| 20 UNDERTAKER | ADDRESS |
|---|---|
| John Grebliauckas F.D. | 423 S Paca St |

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20084 E 20084

## CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 288 S. Carlton St ST. 10-14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucinda Johnson

(a) RESIDENCE NO. 1003 Aisquith St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Lesgth of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, ~~Widowed,~~ or ~~Divorced,~~ (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George D Johnson

6 DATE OF BIRTH (month, day, and year) Mar 11 1889

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 38 | — | 9 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House-work

(b) General nature of industry, business, or establishment in which employed (or employer): general Housework

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Frank Sisco

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Maria Alsup

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): George D Johnson 1003 Aisquith St

15 Filed ... 19 ... Registrar

HARRISON JONES, M. D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 10 / 1927

17

I HEREBY CERTIFY, That I attended deceased from Mar 7 / 19 27 to Mar 10 / 19 27 that I last saw h alive on March 9 / 19 27 and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous nephritis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Probably Syphilis

(duration) not known yrs. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) R L Eschlinger, M. D.

19 (Address) 151 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stevens MD — DATE OF BURIAL: Mar 14 19 27

20 UNDERTAKER: Edward Bryan — ADDRESS: 169 Orleans St

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 20085

## CERTIFICATE OF DEATH.

E 20085

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 760 Colvin St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Myrtenia Osbourne

(a) RESIDENCE NO. 760 Colvins St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | C | Single |

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 12-1905

| 7 AGE Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|
| 21 | 5 | 26 28 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto Md

PARENTS

10 NAME OF FATHER Saml Osbourne

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary Osbourne

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Md

14 Informant Elsie Young

(Address) 1051 Druid Hill Ave

Filed MAR 14 1927 C. HAMPTON JONES, M. D.

By _____ Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb 20, 1927, to March 10, 1927, that I last saw h alive on March 10, 1927 and that death occurred, on the date stated above, at 11:30 p m.

The CAUSE OF DEATH* was as follows:

Pneumonia Bilateral

Lobar

(duration) yrs. mos. 18 ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) [illegible], M. D.

(Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery Date of Burial Mar 15 1927

20 UNDERTAKER Edward Bryan ADDRESS 651 Orleans St

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20086

100-001

## CERTIFICATE OF DEATH

E 20086

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 252 S. 5th St. Highland Town Ward) 26-37

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Reibling

(a) RESIDENCE NO. 252 S. 5th St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Reibling

6 DATE OF BIRTH (month, day, and year) July 11. 1866

| 7 AGE | Years | Months | Days | IF LESS than 1 day ...hrs. or ...min.. |
|---|---|---|---|---|
| | 60 | 8 | 3 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Paris

(State or country) France

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Not Known

14 Informant Mrs Ella Hellerman

(Address) 252 S 5th St

15 Filed MAR 14 1927 19

16 CHARLES JOHN M D Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 27

17 I HEREBY CERTIFY, That I attended deceased from March 1 19 27 to March 11 19 27

that I last saw her alive on March 10 19 27

and that death occurred, on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) 1 yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) [illegible] M. D.

3/11/27 (Address) 405 S Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Mt. Carmel Cemetery | Mar. 14 1927 |
| 20 UNDERTAKER | ADDRESS |
| Henry Sander & Sons Inc | 1710 Fleet St. |

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

Dec 147

E 20087

100-001

E 20087

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

City of BALTIMORE: (~~JOHNS HOPKINS HOSPITAL~~ St. 25-75 Ward)

2-FULL NAME Mary Syrowski

(a) RESIDENCE NO. 904 Wash. Ave. Brooklyn Anne Arundel Co. Md Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 30 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word):

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 12. 1927

7 AGE: Years | Months | Days: 30 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEDENT

(a) Trade, profession or particular kind of work: Infant fed

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Stephen Syrowsky

11 BIRTHPLACE OF FATHER (city or town): Poland

(State or country)

12 MAIDEN NAME OF MOTHER Mary Syrowski

13 BIRTHPLACE OF MOTHER (city or town): Poland

(State or country)

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19..... C. HARRISON JONES, M. D. Registrar

MAR 14 1927 By .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 11, 1927, to March 12, 1927, that I last saw h.. alive on March 12, 1927, and that death occurred, on the date stated above, at 12 5 a.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) .....yrs. .....mos. 3 ds.

CONTRIBUTORY (Secondary)

Prematurity (duration) .....yrs. .....mos. 30 ds.

18 Where was disease contracted

If not at place of death!

Did an operation precede death! no Date of

Was there an autopsy? no

What test confirmed diagnosis! Examination

(Signed) H. E. Handley, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus Cem. | Date of Burial: Mar 14 1927

20 UNDERTAKER: M. J. Sadowski | ADDRESS: 905 Eastern Av

Spec.—1-10-21—M&T—1500 Bks.

Lizzie Cole

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20088

## CERTIFICATE OF DEATH.

1-001

E 20088

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1139 Argyle Ave ST. 17-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lizzie Cole

(a) RESIDENCE No. 1139 Argyle ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 years yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Cole

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE: Years 60 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of Industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Baltimore City

PARENTS

10 NAME OF FATHER: — Bauer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md —

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Harry Cole

(Address): 1139 Argyle Ave

15 Filed 4 1927 ..., 19.. C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 11 1927

17

I HEREBY CERTIFY, That I attended deceased from Mar 9, 1927, to Mar 11, 1927.

that I last saw her alive on Mar 11, 1927.

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) 0 yrs. 0 mos 10 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) 0 yrs. 0 mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Clin. symptoms

(Signed) R B Kenyon, M. D.

3/12, 1927 (Address) 607 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery — DATE OF BURIAL: Mar. 14, 1927

20 UNDERTAKER: Mrs. Kate R. Williams — ADDRESS 322 N. Schroeder St

Spec.—1-12-23—M&T—500 Blks.

E 20089

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 20089

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 315 Dolphin ST. 11-24 WARD) 90

2-FULL NAME Lucy Donaldson

(a) RESIDENCE No. 315 Dolphin ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Mulatto

5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (write the word): Single

6 If ~~married, widowed, or divorced~~ HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year) Aug 26 1846

8 AGE — Years: 80 — Months: 6 — Days: 4 — If LESS than 1 day, hrs or min

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

10 BIRTHPLACE (city or town) (State or country) Eldridge Howard Co Md

PARENTS

10 NAME OF FATHER Thomas Donaldson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary E. P. Dorsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Co Md

14 Informant Charlette D. Humphill

(Address) E. Eldridge Howard Co Md

15 Filed 1-4 1927 HAMPSON JONES, M. D. Registrar

Per RJC

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 1927

17 I HEREBY CERTIFY, That I attended deceased from March 9th 1927 to March 12 1927.

that I last saw h[illegible] alive on March 12 1927

and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Myocarditis — Chronic

(duration) Several yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No —

What test confirmed diagnosis? None —

(Signed) Hamilton M. D.

March 13. 1927 (Address) 327 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Grace Church Cemetery | March 14 1927 |
| 20 UNDERTAKER | ADDRESS |
| Henry W Jenkins Sons Co | Catalina & No Collock St |

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20090

## CERTIFICATE OF DEATH

44 E·20090

1-PLACE OF DEATH

REGISTERED NO. 2334

City of BALTIMORE: (No. 1210 Marshall St., Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joshua S. Watts

(a) RESIDENCE NO. 1210 Marshall St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lilly Watts

6 DATE OF BIRTH (month, day, and year) May 26, 1861

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 65 | 9 | 13 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or partiruiar kind of work Watchman

(b) General nature of industry, business, or establishment in whirh employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Glenburnie

(State or country) Md.

PARENTS

10 NAME OF FATHER William E. Watts

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Glenburnie, Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Emory F. Watts

(Address) 1210 Marshall St.

MAR 14 1927 J. HARRY JONES, Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1927, to Mar 11, 1927

that I last saw h alive on Mar 10, 1927

and that death occurred, on the date stated above, at 3.50 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contrarted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. C. Campbell M. D.

Mar 12 1927 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suiridal, or Homiridal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore County Glenburnie Date of Burial Mar 14 1927

20 UNDERTAKER John F Denny ADDRESS 715 Light St

Spec.-7-17-26—A Co.—200 Bks.

E·20091 HEALTH DEPARTMENT—CITY OF BALTIMORE E·20091

90

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. 27-41

City of BALTIMORE: (No. 3416 Belair Road St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Taylor

(a) RESIDENCE NO. 3416 Belair Road St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah A. Taylor

6 DATE OF BIRTH (month, day, and year) 1840

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| 87 | 86 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Shoe Mfgr.

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Ireland

PARENTS

10 NAME OF FATHER John Taylor

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Jane McLeah

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Mrs. Jesse Hutson

(Address) 3416 Belair Road

15 Filed MAR 14 1927 C. EARNON JONES, Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 11, 19 27

17 I HEREBY CERTIFY, That I attended deceased from Aug 10, 19 26, to Mar 11, 19 27.

that I last saw h living on Mar 10, 19 27.

and that death occurred, on the date stated above, at 11.20 a. m.

The CAUSE OF DEATH* was as follows:

Edema, Myocarditis

Arteriosclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY Terminal, Bronchopneumonia

(Secondary)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Dr. Loyola, M. D.

. 19 (Address) 817 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — Date of Burial Mar 15 1927

20 UNDERTAKER John F Denny — ADDRESS 715 Light St

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20092

CERTIFICATE OF DEATH.

185

E 20092

1-PLACE OF DEATH Balto City Hospls

REGISTERED NO.

City of BALTIMORE: (No. Balto Md St. 8-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Jelinek

(a) RESIDENCE NO. 2003 E Chester St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 Color or Race White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Victor Jelinek

6 DATE OF BIRTH (month, day, and year) 11 8 1865

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 62 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 037

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Bohemia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Balto City Hospls

(Address) Balto Md

Filed MAR 14 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-12 1927

17

I HEREBY CERTIFY, That I attended deceased from 3-3 1927 to 3-12 1927

that I last saw h[illegible] alive on 3-11 1927

and that death occurred, on the date stated above, at 8:25 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

Fracture L Hip

Senile Senility

CONTRIBUTORY (Secondary) Poor Circ

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted, if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) John Goodwin M. D.

3/12/1927 (Address) 1130 Eutaw City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Hill Date of Burial Mar 14 1927

20 UNDERTAKER Paul Crocker ADDRESS 1906 Eutaw

Spec.—1-12-23—M&T—500 Blks.

E 20093 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 20093

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2110 E. Madison St. 7-12 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Visek

(a) RESIDENCE NO. 2110 E Madison ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Luke mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Visek

DATE OF BIRTH (month, day, and year) Not Known

| AGE | Years | Months | Days | If LESS than 1 day, hrs or min |
|---|---|---|---|---|
| | 65 | | | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Bohemia

10 NAME OF FATHER John Visek

11 BIRTHPLACE OF FATHER (City or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

PARENTS

14 Informant Mary Visek

(Address) 2110 E Madison St

15 Filed ... 19 C. HARRISON JONES, Registrar

By

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 12 1927

17 I HEREBY CERTIFY, That I attended deceased from July 5, 1926 to Mar 12, 1927

that I last saw h alive on Mar 12, 1927

and that death occurred, on the date stated above, at 3 A m

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Trouble

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J Reynolds, M. D.

Mar 14, 1927 (Address) 801 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Hill — DATE OF BURIAL May 15 1927

UNDERTAKER E. Frank Erickson — ADDRESS 1906 Gilmor

Spec.—1-10-21—M&T—1500 Bks.

E 20094

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20094

## CERTIFICATE OF DEATH.

REGISTERED NO. 179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 919 S. Belair Rd. ST. Gardenville WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Maenner

(a) RESIDENCE NO. 919 S. Belair Rd. ST. Gardenville WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Maenner

6 DATE OF BIRTH (month, day, and year) Oct 28th 1856

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 70 | 4 | 15 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Truck Farm

(c) Name of employer Retired 10 Years

9 BIRTHPLACE (city or town) Balto Co. (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Unknown

14 Informant Henry Maenner (Address) Fullerton Maryland

15 Filed MAR 14 1927 HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 1927

17 I HEREBY CERTIFY, That I attended deceased from June 5th 1926 to March 12 1927.

that I last saw h alive on March 12th 1927.

and that death occurred, on the date stated above, at 4:45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) Edwd H Bernard M. D.

3/13 1927 (Address) Perkton Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL Mar 15 1927

20 UNDERTAKER Frederick Lauralwood

ADDRESS Fullerton

Cor.—12-9-25—A Co.—200 Bks.

E 20095

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

X 188-003

E 20095

REGISTERED NO._____

1-PLACE OF DEATH Pronounced dead at Johns Hopkins Hospital

City of BALTIMORE: (No. _____ St., 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert Hutschenreuter

(a) RESIDENCE NO. Glenarm, Md St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | White | mar ied |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Hutschenreuter

6 DATE OF BIRTH (month, day, and year) Dec 9, 1860

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 66 | 3 | 3 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Germany

PARENTS

10 NAME OF FATHER August Hutschenreuter

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Germany

14 Informant John Hutschenreuter

(Address) 4623 Belair Rd

MAR 14 1927

C. HARRISON JONES, M. D.

Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 12/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably fractured skull
Struck by automobile near
Glenarm Md/ Accidental

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) _____

(duration) .....yrs. .....mos. .....ds.

(Signed) J. E. H. Pates M. D.

(Coroner)

3/12/27 (Address) 508 E/ Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the state.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Zion Lutheran Cemetery | May. 16, 1927 |
| 20 UNDERTAKER | ADDRESS |
| Frederick Lansdowne | Fullerton |

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20096

## CERTIFICATE OF DEATH.

90

E 20096

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 727 School St., 15-21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Boyer

(a) RESIDENCE NO. 727 School St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 ~~Single, Married,~~ Widowed, or ~~Divorced,~~ (write the word) |
|---|---|---|
| Female | Colored | Widow |

3a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Henry Boyer

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 62 ? | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) A. A. Co

(State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Anne Vaughn

(Address) 727 School St

15 Filed MAR 14 1927 C. HARRISON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 9, 1927, to Mar 11, 1927, that I last saw h~~er~~ alive on Mar 11, 1927 and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 2? yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E William Frey, M. D.

3/11, 1927 (Address) 1928 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Mt. Olivet Cem. Balto Mch 14 1927

20 UNDERTAKER — ADDRESS

Wm. H. Black Son 1400 Madison

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 20097

## CERTIFICATE OF DEATH.

REGISTERED E 20097

1-PLACE OF DEATH Jewish Baltimore Hospital

City of BALTIMORE: (No. 1213 E Lyon St. 20-28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Christopulos

(a) RESIDENCE NO. 2028 W. Pratt St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 8 1926

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | | 4 | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md.

PARENTS

10 NAME OF FATHER George Christopulos

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Greece

12 MAIDEN NAME OF MOTHER Sophie Lannes

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Greece

14 Informant George Christopulos

(Address) 2028 W. Pratt St

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12, 1927 19

17

I HEREBY CERTIFY, That I attended deceased from March 7, 1927, to March 12, 1927,

that I last saw h.. alive on March 12, 1927,

and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Otitis media

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. E. Miller, M. D.

, 19 (Address) Jewish Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem. Date of Burial 3/14/27 19

20 UNDERTAKER Geo. J. Pulls ADDRESS 1731 Eut. St.

MAR 14 1927 HAMILTON JONES, M. D. Registrar

Per

Spec.—12-9-25—A Co.—200 Bks.

1927 E 20098

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

44 E 20098

REGISTERED NO._____

1-PLACE OF DEATH

JOHNS HOPKINS HOSPITAL

City of BALTIMORE: (No._____ St., 8-12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anthony Walker

(a) RESIDENCE NO. 1119 E. Hartford St. City Ward D.

(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Walker

6 DATE OF BIRTH (month, day, and year) 1869

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| 58 | 57 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) Oil

(c) Name of employer

9 BIRTHPLACE (city or town) Scotland

(State or country)

PARENTS

10 NAME OF FATHER Francis Walker

11 BIRTHPLACE OF FATHER (city or town) Scotland

(State or country)

12 MAIDEN NAME OF MOTHER Mary Walker

13 BIRTHPLACE OF MOTHER (city or town) Scotland

(State or country)

14 Informant Records.

(Address)

Filed JOHNS HOPKINS HOSPITAL

APR 14 1927 Per R. McCONKEY JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 2, 1927, to March 12, 1927, that I last saw him alive on March 12, 1927, and that death occurred, on the date stated above, at 3.55 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach, inoperable.

(duration) yrs. 5½ mos. ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Not known.

Did an operation precede death? yes Date of? Feb 7, 1927

Was there an autopsy? yes.

What test confirmed diagnosis? Exploratory Laparotomy

(Signed) Henry K. Ritzmann, M. D.

, 19 (Address) Johns Hopkins Hosp. Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| New Cathedral Cem | May 18 1927 |
| UNDERTAKER | ADDRESS |
| Geo M. Arnold Son | 811 N Wolfe |

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20099 — CERTIFICATE OF DEATH. — 21-31 154 — E 20099

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 1120 China ST. (or WARD) 21-31

2-FULL NAME Annie Queen

(a) RESIDENCE NO. 1120 China ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifted mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Tress Queen

6 DATE OF BIRTH (month, day, and year): 1877

7 AGE — Years: 50. Months: Days: If LESS than 1 day, hrs or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer): Out

(c) Name of employer:

9 BIRTHPLACE (City or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Sarah Martin 231 N. Pennsylvania Ave

15 Filed MAR 14 1927 19 C. HAMILTON JONES, M. D. Registrar Per

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 27, 1927, to March 11, 1927, that I last saw her alive on March 11, 1927, and that death occurred, on the date stated above, at 11 9 m.

The CAUSE OF DEATH* was as follows:

Ulcers of the leg (duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Septicemia (duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? None

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) 1627 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn

DATE OF BURIAL: 3/14 1927

20 UNDERTAKER: Samuel Hemsley

ADDRESS: 1631 Eutaw St

Spec-12-23-21—E.B.R.S.—400 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20100 E 20100

## CERTIFICATE OF DEATH.

Registered No. 20-27 29

1-PLACE OF DEATH

City of BALTIMORE: (No. 400 N. Fulton Ave St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Maryan McCommas

(a) Residence No. Home for the Aged of the M.E. Church Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 25 1854

7-AGE. 72 yrs. 8 mos. 17 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). New York

PARENTS

10-NAME OF FATHER. William Fenton

11-BIRTHPLACE OF FATHER (city or town) (State or Country). England

12-MAIDEN NAME OF MOTHER. Marian Davis

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). England

11- (Informant) Etta Cuddy

(Address) 400 N Fulton Ave

15- Mar 14 1927 C. HARRISON JONES, M. D. Registrar.

By RH

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Mch 12, 1927

17- I HEREBY CERTIFY, That I attended deceased from Dec 12 1926 to Mch 12 1927 that I last saw h. alive on Mch 11 1927 and that death occurred, on the date stated above, at 11.30a m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 2 yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) Endocarditis

(Duration) ✓ yrs. 3 mos. ✓ ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical Methods

(Signed) George C. Harmon M. D.

3/14, 1927 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Greenmount DATE OF BURIAL. Mar. 14. 1927

20-UNDERTAKER. George J Smith ADDRESS 1532 Hollins

Wallis

# HEALTH DEPARTMENT---CITY OF BALTIMORE

E 20101

1 PLACE OF DEATH

## CERTIFICATE OF DEATH

100 E 20101

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 4116 Kathland Ave St. 31-64 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rose Wallis

(Residence in Baltimore: No. 4116 Kathland Ave St.; yrs. mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Fem

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widow

6-DATE OF BIRTH: Dec 28 (Month) 1850 (Day) (Year)

7-AGE: 76 yrs 3 mos 15 ds. If LESS than 1 day, hrs., or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer): 00

9-BIRTHPLACE (State or country): Baltimore

PARENTS

10-NAME OF FATHER: Nicholas A McComas

11-BIRTHPLACE OF FATHER (State or country): Balto Md.

12-MAIDEN NAME OF MOTHER: Laura Anderson

13-BIRTHPLACE OF MOTHER (State or country): Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs M Sula Elliott

(Address) 4116 Kathland Ave

15-

Filed MAR 14 1927 191 C. HAMILTON JONES, M. H. REGISTRAR

Per K.L.

### MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: March (Month) 13 (Day) 1927 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 4, 1927, to, March 13 1927, that I saw h-r alive on March 13 1927, and that death occurred, on the date stated above, at 0 m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) yrs mos 9 ds

Contributory (SECONDARY) old age

(Duration) yrs mos ds.

(Signed) W H Gough M. D.

3-14 1927 [Address] 117 W Saratoga St

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Forest Hill Cemetery MD DATE OF BURIAL: Mar 16, 1927

20-UNDERTAKER: George J Smith ADDRESS: 453 Hollins

Spec.—7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20102

## CERTIFICATE OF DEATH

3 E 20102

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 207 N Rose St. 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph V Hannan

(a) RESIDENCE NO. 207 N Rose St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced RUSBAND of (or) WIFE of Margaret Hannan

6 DATE OF BIRTH (month, day, and year) July 28 1877

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 49 | 8 | 17 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Huckster

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Mrs Margaret Hannan

(Address) 207 N Rose St

15 Filed MAR 4 1927 H. HAMPTON JONES, M. D. Registrar

Per KR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 1927

17 I HEREBY CERTIFY, That I attended deceased from March 5, 1927, to March 17 1927.

that I last saw him alive on March 17, 1927.

and that death occurred, on the date stated above, at 1.55 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis (Caseous & Cavernous Type)

(duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency Pulmonary Edema

(duration) yrs. mos. 4 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. G. Geyer M. D.

, 19 (Address) 156 N. Midland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity — Date of Burial 3/15 1927

20 UNDERTAKER Louis Heemann — ADDRESS 3r S Bway

Spec.—1-10-21—M&T—1500 Bks.

E 20103 HEALTH DEPARTMENT—CITY OF BALTIMORE E 20103

# CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 924 Fayette St. West Baltimore

CITY OF BALTIMORE: (No. ..... ST., 16 WARD)

2-FULL NAME Mrs Catherine Berry

(a) RESIDENCE NO. 924 W Fayette St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Orbite | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Egan H. Berry

6 DATE OF BIRTH (month, day, and year) Mar 6 1857

| 7 AGE | Years | Months | Days | If LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 70 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) Ireland

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Wm H. Coyne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant John Berry

(Address) 924 W Fayette st

15 Filed Mar 14 1927 C. HAMPSON JONES, M. D. Registrar

By RF

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 13 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 10, 1927, to Mar 13, 1927, that I last saw h 4 alive on Mar 11, 1927 and that death occurred, on the date stated above, at 9:20 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Physical Signs

(Signed) Wallace Winter, M. D.

, 19 (Address) Franklin Square Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral DATE OF BURIAL Mar 17 1927

20 UNDERTAKER John F. Falls ADDRESS 1200 W Lombard st

Spec.—6-9-19—H. P. Co.—1000 Blks.

E 20104

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20104

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 15-68

CITY OF BALTIMORE: (No.) 2133 Herbert (St.) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia F. Green King

(a) RESIDENCE. No. 2133 Herbert St. (Ward)

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| F | W | M. |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gilbert King

6 DATE OF BIRTH (month, day, and year) Feb 16 85

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 42 | — | 26 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home work

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John Keener

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mt Kuhn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mt Kuhn

14 Informant (Address) Mr Green 2133 Herbert St

15 Filed 3/14, 1927. HAMILTON JONES, M. D., Registrar.

By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12, 1927

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1926, to March 12, 1927.

that I last saw her alive on March 12, 1927.

and that death occurred, on the date stated above, at 9.30A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

about 1 yrs. mos. ds.

(duration)

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? YES Date of July 15, 1926

Was there an autopsy? NO

What test confirmed diagnosis? laboratory.

(Signed) J. T. Hennessy, M. D.

(Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem

DATE OF BURIAL: March 15 27

20 UNDERTAKER: H M Routson

ADDRESS: 2238 W North

Spec.—12-9-25—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20105
1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

101-001

E 20105
REGISTERED NO.

City of BALTIMORE: (No. 32 E. White Av 27-43 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harvey W. Denton

(a) RESIDENCE NO. 32 E. White Av St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE)~~ of late Marie M. Denton

6 DATE OF BIRTH (month, day, and year) Dec 24/83

7 AGE: Years 43 | Months 2 | Days 18/16 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer & Supt

(b) General nature of industry, business, or establishment in which employed (or employer) Machine Shop

(c) Name of employer House

9 BIRTHPLACE (city or town) City

(State or country)

PARENTS

10 NAME OF FATHER John W. Denton

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Sallie O. Ward

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Nellie Denton

(Address) 32 E White Av

4 1927 C. HAMPTON JONES, M. D.

Per R.C. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

March 12 1927

17

I HEREBY CERTIFY, That I attended deceased from March 7, 1927, to March 12, 1927, that I last saw h[illegible] alive on March 12, 1927, and that death occurred, on the date stated above, at 3.55 p. m.

The CAUSE OF DEATH* was as follows:

Coron Pneumonia

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Fritz S Klinger, M. D.

3 in. 1927 (Address) 2700 Hoffman Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn — Date of Burial: 3/15 1927

20 UNDERTAKER: Philip Henry — ADDRESS 2016 Aliceanna

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

122-002

E 20106

## CERTIFICATE OF DEATH.

E 20106

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 845 Washington Blvd Ward) B 24-29

2-FULL NAME Charles S Seligman.

(a) RESIDENCE NO. 845 Washington Blvd Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Gertrude M. Haug.

6 DATE OF BIRTH (month, day, and year): Dec 4th 1885

7 AGE: Years 41 Months 3 Days 7. IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Dairy milker.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Jacob Seligman.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Helen Mansfield

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore, Md.

14 Informant: Mrs. Gertrude M. Seligman

(Address) 845 Washington Blvd

15 1927 C. [illegible] Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 11th 1927

17

I HEREBY CERTIFY, That I attended deceased from Nov 1st, 1926, to March 11, 1927, that I last saw h[illegible] alive on March 10, 1927, and that death occurred, on the date stated above, at 11:40 P. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of liver (cause)

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Diabetes

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

March 14, 1927 (Address) 57 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn, Md. Date of Burial 3/15/1927

20 UNDERTAKER: Judge & Son. ADDRESS 60 E. F. Cowan. 901 Eutaw St.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

**E 20107**

**CERTIFICATE OF DEATH.**

93 ✓ **E 20107**

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1530 Division St. 14-20 Ward)

2-FULL NAME Emma J Bragg

(a) RESIDENCE NO. 1530 Division St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Bragg

6 DATE OF BIRTH (month, day, and year): [illegible] 1873

7 AGE: Years 54; Months; Days; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): " " -

(c) Name of employer

9 BIRTHPLACE (city or town): Easton

(State or country): Md

PARENTS

10 NAME OF FATHER: Peter Miller

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Md.

12 MAIDEN NAME OF MOTHER: - - -

13 BIRTHPLACE OF MOTHER (city or town): Md

(State or country)

14 Informant (Address): Herman Bragg 1530 Division St

15 Filed MAR 14 1927 C. HAMPSON WHITE, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/12/1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 14 1927 to Mar 12 1927

that I last saw h[illegible] alive on Mar 12 1927

and that death occurred, on the date stated above, at 6:26 a m.

The CAUSE OF DEATH* was as follows:

acute Toxemia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Broken Varicose Ulcer of Foot

(duration) yrs. 2 mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Surgical

(Signed) John H. Fotterman M. D.

3/14 1927 Address 1017 Linwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery Easton Md

Date of Burial: Mar 15 27

20 UNDERTAKER: Mrs R. G. Elliott

ADDRESS: Oakland Md

Spec.-7-17-26—A Co.—200 Bks.

E 20108

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

49

E 20108

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL 16-67 REGISTERED NO.

City of BALTIMORE: (No. 2904 Riggs Ave St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena L. Baggett

(a) RESIDENCE NO. 2904 Riggs Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 20, 1877

| 7 AGE | Years | Months | Days | IF LESS than 1 day ...hrs. or ...min.. |
|---|---|---|---|---|
| | 49 | 3 | 22 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Indiana

(State or country)

PARENTS

10 NAME OF FATHER Chris. Hafele

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothy Benns

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant James N. Baggett

(Address) 2904 Riggs Ave

Filed MAR 14 1927 C. HAMILTON JONES, Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Nov. 3, 1926, to Nov 15, 1926, that I last saw him alive on Nov. 15, 1926 and that death occurred, on the date stated above, at 10:30 p m.

The CAUSE OF DEATH* was as follows:

Brain Tumor

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of 11/3/26 - 11/6/26 & 11/13/26

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harvey Cushing, M. D.

(Address) George L. Tiffney, The Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — Date of Burial Mar 14 1927

20 UNDERTAKER George J Smith — ADDRESS 153 Hollins

Spec.–7-17-26—A Co.—200 Blks.

20109

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

101-001

E 20109

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Rusk Ave St. Ridgely Ave Ward) 55

(If death occurred in a hospital or institution, give its NAME instead of street and number.) Mt Wash Hosp

2-FULL NAME Annie E Steck

(a) RESIDENCE NO. Rusk Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Femal

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Late Louis Steck

6 DATE OF BIRTH (month, day, and year): Feb 23. 1858

7 AGE: Years 69 Months Days 20 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country)

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (City or town): Unknown

(State or country)

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (City or town): Unknown

(State or country)

14 Informant: Catherine Hughes

(Address) Rusk & Ridgely

15 Filed MAR 14 1927 19 C. HAMPSON JONES Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 13 1927

17 I HEREBY CERTIFY, That I attended deceased from Mch 9 1927, to Mch 13 - 1927, that I last saw her alive on Mch 13 - 1927, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Double Lobar Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY Senility

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of -

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) E C Nichols, M. D.

3/14/ 1927. (Address) Parkville Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem Date of Burial March 15 1927

20 UNDERTAKER: Eichenwald Son ADDRESS 3617 Eastern Ave

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20110

CERTIFICATE OF DEATH. 46

REGISTERED NO. E 20110

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospitals St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Della Ball

(a) RESIDENCE NO. 3655 Chestnut ave St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 Color or Race White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John A Ball

6 DATE OF BIRTH (month, day, and year) Sep 20 1901

7 AGE 25 Years 26 | Months 6 | Days 23 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Factory work

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) Va

(State or country)

PARENTS

10 NAME OF FATHER Luther Bladwell

11 BIRTHPLACE OF FATHER (city or town) Va

(State or country)

12 MAIDEN NAME OF MOTHER Hattie B Elliott

13 BIRTHPLACE OF MOTHER (city or town) Va

(State or country)

14 Informant John Ball

(Address) 3655 Chestnut Ave

15 Filed APR 14 1927 H. HARRISON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13, 1927

17 I HEREBY CERTIFY, That I attended deceased from 3-4 1927, to 3-13 1927, that I last saw h.. alive on 3-13 1927, and that death occurred, on the date stated above, at 6-50 a.m.

The CAUSE OF DEATH* was as follows: Pneumonia Lobar

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) H. P. Fezzetti M. D.

, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Moriah Hampden Date of Burial March 16 27

20 UNDERTAKER Chenoweth & Son ADDRESS 345 Chestnut Ave

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

20111

CERTIFICATE OF DEATH.

101-901 E 20111

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St., 12-20 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Willis Coleman

(a) RESIDENCE NO. 1812 Mayland St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Negro | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1897

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 30 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter 10

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Vienna

(State or country) Mayland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ?

(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?

(State or country)

14 Informant BALTIMORE CITY HOSPITALS

(Address) Records

15 Filed 19 [illegible] 19 [illegible]

MAR 14 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 1927

17

I HEREBY CERTIFY, That I attended deceased from March 11, 1927, to March 12, 1927, that I last saw him alive on March 11, 1927, and that death occurred, on the date stated above, at 4:15 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? general & laboratory

(Signed) R. Hooper Lamb, M. D.

March 13 1927 BALTIMORE CITY HOSPITALS (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hemlock, Md. Date of Burial 3/15/1927

20 UNDERTAKER E. A. Holland ADDRESS 1631 D. Hill ave

Spec.—12-9-25—A Co.—200 Bks.

E 20112

# HEALTH DEPARTMENT—CITY OF BALTIMORE

122-002 E 20112

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO. 2515

City of BALTIMORE: (No. [redacted] St., [illegible] Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Martin

(a) RESIDENCE NO. 1541 Pennington Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widowed |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1858

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 69 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stone Cutter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Samuel Martin

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Elizabeth —

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant

(Address) Records

15 1927 19 [illegible] Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 1927

17

I HEREBY CERTIFY, That I attended deceased from January 12, 1927, to March 12, 1927, that I last saw him alive on March 11, 1927, and that death occurred, on the date stated above, at 2 30 A m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of the Liver

(Etiology) (Form)

(duration) yrs. 2 mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death!

Did an operation precede death! no Date of

Was there an autopsy! no

What test confirmed diagnosis! general laboratory

(Signed) S. D. Hooper Smith, M. D.

March 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — Date of Burial: Mar 15 1927

20 UNDERTAKER: James Hynes — ADDRESS: 1324 Eutaw

BALTIMORE CITY HOSPITALS CERTIFICATION

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

**20113** **E 20113**

## CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St. 5-6 Ward)

2-FULL NAME Joseph S. Rogers

(a) RESIDENCE NO. 100 N. Front St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | ? |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1854

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..hrs. or ..min. |
|---|---|---|---|---|
| | 73 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Wm Rogers

11 BIRTHPLACE OF FATHER (city or town)

(State or country) N. C.

12 MAIDEN NAME OF MOTHER Mary —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 BALTIMORE CITY HOSPITALS Informant

(Address) Records

C. HAMPSON JONES, M. D.

1927 Per 1140 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9 1927

17

I HEREBY CERTIFY, That I attended deceased from August 11, 1926, to March 9, 1927, that I last saw h[illegible] alive on March 9, 1927, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? general & laboratory

(Signed) R Hampson Jones, M. D.

March 12 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

UNIVERSITY OF MARYLAND 19

20 UNDERTAKER ADDRESS

MAR 12 1927

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20114

## CERTIFICATE OF DEATH.

3/ E 20114

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St. 1637 Ward)

2-FULL NAME Letty Jackson

(a) RESIDENCE NO. BALTIMORE CITY HOSPITALS St. _____ Ward _____

(Usual place of abode) [redacted] (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Negro | Widowed |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1867

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 60 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Hanns Dennis

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Catherine Hanns

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant _____

(Address) [redacted] Records

15 Filed 1927 11 30 G. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1927

17 I HEREBY CERTIFY, That I attended deceased from March 4, 1927, to March 10, 1927, that I last saw her alive on March 10, 1927, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis (active)
Cavitation with apnea

(duration) ____ yrs. ? mos. ____ ds.

CONTRIBUTORY _____
(Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted

If not at place of death? _____

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis? Gennal & Laboratory

(Signed) R. Hartzell Leuth, M. D.

March 12 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Date of Burial 3/22/27 19

UNDERTAKER J. Thomas Skinner ADDRESS 1625 E. Monument St.

BALTIMORE CITY HOSPITALS
UNIVERSITY OF MARYLAND
MAR 15 1927
Commissioner Health

Spec.—12-9-25—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20115

## CERTIFICATE OF DEATH.

90 E 20115

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospital Ward) 16-37

2-FULL NAME Henry Goldhammer

(a) RESIDENCE NO. Balto city Hospital St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): widowed

5a If married, widowed, or divorced
BUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1856

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 71 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) —

(State or country)

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) —

(State or country)

14 Informant

(Address)

15 Filed _____, 19 C. HAMPSON JONES M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 3-10-27

17

I HEREBY CERTIFY, That I attended deceased from 3-16-, 1927, to 3-10-, 1927

that I last saw him alive on 3-10, 1927

and that death occurred, on the date stated above, at 5:45 p.m.

The CAUSE OF DEATH* was as follows:

Tetro Sebotic Cardio Vascular disease, Chronic Myocarditis Varicose ulcer Right Leg

(duration) Unknown ds.

CONTRIBUTORY Bronchopneumonia

(Secondary)

(duration) ____ yrs. ____ mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) H. Barnard M. D.

, 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 DISPOSAL BY BURIAL, CREMATION OR REMOVAL Potters Field Date of Burial MAR 12 1927, 19

20 UNDERTAKER (Commissioner Health) ADDRESS 115 E Mont St.

E. P. Kane (SEALED)

Certificate received MAR 14 1927

UNIVERSITY OF MARYLAND

Spec.—12-9-25—A Co.—200 Blks.

1998 E 20116

HEALTH DEPARTMENT—CITY OF BALTIMORE 4... 942

CERTIFICATE OF DEATH. X 96 E 20116 A. m.

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jerald Hayes

(a) RESIDENCE NO. 646 S. Holmes St. Ward Kansas City Mo.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Estelle K. Kimball

6 DATE OF BIRTH (month, day, and year) Dec 16, 1883

| 7 AGE Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|
| 43 | 2 | 28 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Journalist - Ed

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Kentucky
(State or country)

PARENTS

10 NAME OF FATHER John Hayes

11 BIRTHPLACE OF FATHER (city or town) Ky
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Hampton

13 BIRTHPLACE OF MOTHER (city or town) Ky
(State or country)

14 Informant Friends
(Address) JOHNS HOPKINS HOSPITAL

15 Filed 4 1927 C. HAMPSON JONES, M. D. Registrar
Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 6 1927, to March 14, 1927, that I last saw him alive on March 14, 1927, and that death occurred, on the date stated above, at 9:30 a. m.

The CAUSE OF DEATH* was as follows:

General Paresis treated with Malaria (history)
(duration) 2½ yrs. mos. ds.

CONTRIBUTORY (Secondary) Septicemia
(duration) yrs 3 wks. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) Wm Lindsay Miller M. D.

3/14/27 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR Ashland, Ky. Date of Burial Mch. 14 1927

20 UNDERTAKER John O. Mitchell ADDRESS 1900 Eutaw Place

Spec.—7-17-26—A Co.—200 Bks.

E 20117

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

90 E 20117

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 116 S. Castle St., 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gollieb P. Buettner.

(a) RESIDENCE NO. 116 S. Castle St. 2 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. 5 mos. 6 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Helen Buettner.

6 DATE OF BIRTH (month, day, and year) Oct 5th 1851

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 75 | 5 | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER Frederick Buettner

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany.

14 Informant Helen Buettner (Wife)

(Address)

15 APR 4 1927 C. HARRISON JONES, M. D. Registrar

Per AKW

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 Mch 11th

17 I HEREBY CERTIFY, That I attended deceased from Jan. 10 1926, to Mch 11 1927, that I last saw h[illegible] alive on Mch 11 1927, and that death occurred, on the date stated above, at 12 00 m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart

Trouble (duration) 14 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William H. Davis M. D.

(Address) 801 N. Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — Date of Burial: Mch 17th 1927

20 UNDERTAKER: Lilly & Zeiler — ADDRESS: 4a[illegible]

Spec.–7-17-26–A Co.–200 Bks.

20118

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

90 E 20118

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1912 Bauld St. 7-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary R. Deckert.

(a) RESIDENCE NO. 1912 Bauld St. 2 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of late John F. Deckert

6 DATE OF BIRTH (month, day, and year) Dec 6th 1856

| 7 AGE | Years | Months | Days | IF LESS than 1 day ...hrs. or ...min.. |
|---|---|---|---|---|
| | 70 | 3 | 7 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER John Propst.

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Madalina Buettner

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany.

14 Informant Joseph P. Deckert (Son)

(Address) 1912 Bauld St.

15 Filed ... 19 ... C. HAMPSON JONES, M. D.

4 1927 Per AKK Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13th 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 17 1927, to March 13 1927.

that I last saw her alive on March 13 1927.

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) Valvular Dis. Heart

(duration) ... yrs. 6 mos. ... ds.

18 Where was disease contracted

If not at place of death? At home

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Chas D. Deen, M. D.

3-14-1927 (Address) 4085 Belt Pk in

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ital. Redeemer Cemetery

Date of Burial: 3-18 1927

20 UNDERTAKER: Lilly & Zeiler

ADDRESS: [illegible]

Spec.-7-17-26—A Co.—200 Bks.

E 20119

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

31 E 20119

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2811 Elliott St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lydia H. Herrmann

(a) RESIDENCE NO. 2811 Elliott St. 1 Ward 1st

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. 9 mos. 2 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ernest Herrmann

6 DATE OF BIRTH (month, day, and year) June 11, 1900

| 7 AGE | Years | Months | Days | IF LESS than 1 day..... hrs. or .....min.. |
|---|---|---|---|---|
| | 26 | 9 | 2 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home work

(b) General nature of industry, business, or establishment in which employed (or employer) 37

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Joseph C. Sullivan

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Baltimore

12 MAIDEN NAME OF MOTHER Catherine R. Cronan

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore

14 Informant Mrs. Ruth Freund

(Address) 2811 Elliott St

15 Filed ..... 19 ..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-13-1927

17 I HEREBY CERTIFY, That I attended deceased from April, 1924 to March 13, 1927.

that I last saw her alive on March 12, 1927.

and that death occurred, on the date stated above, at 7:58 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) J. B. Broughas M. D.

(Address) 3037 O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery — Date of Burial: Mch 17 1927

20 UNDERTAKER: Lilly & Zieler — ADDRESS: 4030 ... St

Spec.—12-9-25—A Co.—200 Bks.

20120

# HEALTH DEPARTMENT—CITY OF BALTIMORE

164 E·20120

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor 10-14 St., Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura Rountree

(a) RESIDENCE NO. Preston + Valley St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | W | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 85 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Samuel Rowley

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore

12 MAIDEN NAME OF MOTHER Ella Lorraine

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Little Sisters of the Poor

(Address)

4 1927 C. HARRISON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927

March 13

17 I HEREBY CERTIFY, That I attended deceased from No record, 19..., to ..., 19...

that I last saw her alive on ..., 19...

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Senile Dementia

Unknown (duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. A. Wrenn, M. D.

March 13, 1927 (Address) 1133 Valley St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount — Date of Burial: March 15 1927

20 UNDERTAKER: Rita Wiedefeld — ADDRESS: 914 Fremont Ave

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20121

E 20121

48

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospital 10-4 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Murray

(a) RESIDENCE NO. 923 Valley St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anne Murray

6 DATE OF BIRTH (month, day, and year): Oct 1855

7 AGE: Years 71 | Months 5 | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): N.C.R.R.

(c) Name of employer

9 BIRTHPLACE (city or town): Ireland

(State or country)

PARENTS

10 NAME OF FATHER: Patrick Murray

11 BIRTHPLACE OF FATHER (city or town): Ireland

(State or country)

12 MAIDEN NAME OF MOTHER: Mary Myer

13 BIRTHPLACE OF MOTHER (city or town): Ireland

(State or country)

14 Informant: Mrs. Griffith

(Address) 1402 S. Charles St

15 1927 C. HARRISON JONES, M. D.

Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: 3-13-27

17 I HEREBY CERTIFY, That I attended deceased from 3-4 19 27, to 3-13 19 27

that I last saw him alive on 3-13 19 27

and that death occurred, on the date stated above, at 3:30 m.

The CAUSE OF DEATH* was as follows:

Epithelioma of face

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Bronchitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. Harrison Jones M. D.

19 (Address) Balto City Hospl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Date of Burial: May 16 19 27

20 UNDERTAKER: Rita Wiedefeld ADDRESS: 914 Fremont Ave

Cor.—12-9-25—A Co.—200 Bks.

E 20122

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

100-001

E 20122

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. 27-56 Ward)

2-FULL NAME Albert B. Weiss

(a) RESIDENCE NO. 5220 Queensbury Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | white | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Weiss

6 DATE OF BIRTH (month, day, and year) 3-30 1881

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 45 | 11 | 13 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Hungary

PARENTS

10 NAME OF FATHER Vilmos Weisz

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Hungary

12 MAIDEN NAME OF MOTHER Regina

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Hungary

14 Informant Rose Weiss

(Address) 5220 Queensbury Ave

15 Filed 4 1927 Per C. HAMPSON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/13 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

Bronchopneumonia (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Harold Feldman M. D.

(Coroner)

3/ , 19 27 (Address) 3325 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem. Date of Burial 3/16 1927

20 UNDERTAKER Jack Lewis ADDRESS 1439 Eastern Ave

Spec.—12-9-25.—A Co.—200 Bks.

E 20123

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20123

## CERTIFICATE OF DEATH.

11-24 31

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St., 11-B Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Drayton

(a) RESIDENCE NO. 820 Tyson st. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | Colored | Married |

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia Drayton

6 DATE OF BIRTH (month, day, and year) 1895

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 32 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) South Carolina

PARENTS

10 NAME OF FATHER Prince Drayton

11 BIRTHPLACE OF FATHER (city or town)

(State or country) South Carolina

12 MAIDEN NAME OF MOTHER Charlotte Pinkney

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) South Carolina

14 Informant Hospital Records

(Address)

Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 March 10, 1927

17

I HEREBY CERTIFY, That I attended deceased from March 8, 19 27, to March 10, 19 27,

that I last saw him alive on March 10, 19 27,

and that death occurred, on the date stated above, at 3.10 P.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tbc.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

3-11-27 W E Gatten, M. D.

(Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem. Date of Burial March 14/27

20 UNDERTAKER Daniel Carbin ADDRESS Balto. 946

ec.—1-12-23—M&T—500 Bks.

E 20124

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20124

## CERTIFICATE OF DEATH.

101-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 516 W 27th ST., 9-50 WARD)

2-FULL NAME Marie Katherine Garmhausen

(a) RESIDENCE NO. 516 W 27th ST., ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

3 If married, widowed, or divorced HUSBAND of (or) WIFE of Milton Garmhausen

DATE OF BIRTH (month, day, and year) Feb 22 1872

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 55 | | 6 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) New Jersey

10 NAME OF FATHER Edward Lauman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Elizabeth Ennis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

Informant Marian Garmhausen

(Address) 516 W 27

Filed ..... 19 ..... Registrar

MAR 24 1927 C. HAMPSON JONES, M. D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 1927

17 I HEREBY CERTIFY, That I attended deceased from March 8, 1926, to March 12, 1927, that I last saw h is alive on March 12, 1927, and that death occurred, on the date stated above, at 11.20 a m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

Duration

CONTRIBUTORY (Secondary) Lobar Pneumonia (duration) 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) C. C. Hampson Jones M. D.

March 13, 1927 (Address) 112 W. 20th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Philadelphia Pa — DATE OF BURIAL March 15 1927

20 UNDERTAKER E. LeRoy Leffler — ADDRESS 1252 North Ave

Spec.-7-17-26—A Co.—200 Bks.

E 20125

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

101-001

E 20125

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 415 N Chapel St. 6-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances. Fisher

(a) RESIDENCE NO. 415 N Chapel St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 Color or Race White

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Fisher

6 DATE OF BIRTH (month, day, and year) May 15. 1854

7 AGE Years 72 Months 9 Days 27 25

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany (State or country)

PARENTS

10 NAME OF FATHER Thomas. Lines

11 BIRTHPLACE OF FATHER (City or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Muthupine

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Sue Fisher (Address) 415. N. Chapel St

Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 12- 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 6 1927 to Mar 12 1927 that I last saw h[illegible] alive on Mar 12 1927 and that death occurred, on the date stated above, at 9:12 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Diabetes

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death? — —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? By Gland

Mar 13 1927 (Signed) Geo. C. Gaul, M. D.

(Address) 745 N. Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — Date of Burial 3-15. 1927

20 UNDERTAKER H. Brauning Son — ADDRESS 517 N Schroeder St

ec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

20126 E 20126

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mt Hope Retreat REGISTERED NO. 129

CITY OF BALTIMORE: (No. 1622 St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillie Mary McAllister

(a) RESIDENCE NO. 836 N Fulton Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widowed |

If married, widowed, or divorced HUSBAND of (or) WIFE of George W. McAllister

DATE OF BIRTH (month, day, and year) Dec. 24, 1872

| AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 54 | 2 | 17 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

10 NAME OF FATHER Wm B Boyer.

11 BIRTHPLACE OF FATHER (city or town) Phila.
(State or country) Pa

12 MAIDEN NAME OF MOTHER Mary R. Elder

13 BIRTHPLACE OF MOTHER (city or town) Lykesville
(State or country) Md

Informant Mt Hope Retreat
(Address) Mt Hope Retreat

Filed 19 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13 1927

17 I HEREBY CERTIFY, That I attended deceased from March 5, 1927, to March 13, 1927,

that I last saw her alive on March 13, 1927,

and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Parenchymatous Nephritis
(Uraemic Coma

Unknown (duration) yrs. mos. dy.

CONTRIBUTORY (Secondary) None - Depressive Psychosis

(duration) 1 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Chemical + Physical

(Signed) Milton P. Dell M. D.

3-13 1927 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Loudon Park Cemetery | Mar. 15 1927 |

20 UNDERTAKER Joseph D Cook ADDRESS 1003 Park Ave

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20127.

# CERTIFICATE OF DEATH.

E 20127

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. German Aged Home Baltimore and Payson Sts. 70-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria A. Steenson

(a) RESIDENCE NO. German Aged Home St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) August 3rd 1848

| 7 AGE Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|
| 78 | 7 | 10 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Switzerland

PARENTS

10 NAME OF FATHER Johann Mueller

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Switzerland

12 MAIDEN NAME OF MOTHER Gertrude Martin

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Switzerland

14 Informant Keeper German Aged Home

(Address) Eutaw and Payson Sts

15 Filed C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13 19 27

17

I HEREBY CERTIFY, That I attended deceased from 3/5/27, 19..., to 3/13/27, 19...,

that I last saw h-r alive on 3/12/27, 19...,

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ...yrs. ...mos. 7 ds.

CONTRIBUTORY (Secondary) Tuberculosis Pulmonalis

(duration) 2 yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John North, M. D.

, 19 (Address) 1843 W. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem Date of Burial Mar 15 19 27

20 UNDERTAKER Fred'k Cook ADDRESS 1003 W Baltimore St

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

20128

## CERTIFICATE OF DEATH.

90 E 20128

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 650 W. Conway St. 27-30 Ward)

2-FULL NAME Matilda Withers

(a) RESIDENCE NO. 650 W. Conway St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. c mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas W. Withers

6 DATE OF BIRTH (month, day, and year): Jan 25 1865

7 AGE: Years 62 | Months 1 | Days 16 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None do

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country): Virginia

PARENTS

10 NAME OF FATHER: Richard B Lawson

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Virginia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Virginia

14 Informant: Estella Taylor

(Address): 4221 Potter St

15 1927 C. HAMPSON JONES, M. D. Registrar

Fee Paid

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 13 1927

17 I HEREBY CERTIFY, That I attended deceased from October 5 1926 to March 13th 1927.

That I last saw h... alive on Saturday March 12 1927

and that death occurred, on the date stated above, at 12 P.M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. E. Poulton, M. D.

3/14 1927 (Address) 3909 Fairmount Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery Date of Burial March 15 1927

20 UNDERTAKER: for Joerdens Son ADDRESS 2178 Pac

Spec.—1-10-21—M&T—1500 Bks.

20129

# HEALTH DEPARTMENT—CITY OF BALTIMORE

20129

## CERTIFICATE OF DEATH.

REGISTERED NO. 1568 57

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST. WARD)

2-FULL NAME Mrs. Isaac Solomon

(a) RESIDENCE No. 2543 Woodbrook Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs. Rebecca Solomon

6 DATE OF BIRTH (month, day, and year): 4-17-1854

7 AGE: Years 67 Months 10 Days 24 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Floorman

(b) General nature of industry, business, or establishment in which employed (or employer): Breyer & Thalheimer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): ~~Germany~~ Baltimore Md.

PARENTS

10 NAME OF FATHER: Phillip Solomon

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Theresa Schwartzhaupt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Hosp. Records (Address)

15 1927 Per 19 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3-13-1927

17 I HEREBY CERTIFY, That I attended deceased from 3-3-, 1927, to 3-13, 1927, that I last saw h/M alive on 3-13, 1927, and that death occurred, on the date stated above, at 10.20 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Diabetic gangrene Left foot)

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary): Pulmonary embolism

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? (Home)

Did an operation precede death? Yes Date of 3-11-27

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) C. C. Sunderman M. D.

, 19 (Address) Md. Gen'l Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship Cem. DATE OF BURIAL: 3/16/1927

20 UNDERTAKER: Chas. F. Grant & Son ADDRESS: 1180 W. Mt. Royal Ave

Dec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

20130

## CERTIFICATE OF DEATH.

118 E 20130

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Baltimore Gen. Hosp ST. 25-64 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Margaret King

(a) RESIDENCE NO. 5017 Liberty Heights ST. One WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs — mos — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | white | Widow |

If married, widowed, or divorced HUSBAND of or) WIFE of James E. King

DATE OF BIRTH (month, day, and year) Aug 11 1865

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 61 | 7 | 2 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) W. Va. (State or country)

10 NAME OF FATHER Patrick King

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER Mary Moran

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

Informant West Baltimore Gen. Hosp (Address)

Filed 4 1927 C. HAMPSON JONES, M. D. Registrar

Par 804

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/13 1927

17 I HEREBY CERTIFY, That I attended deceased from 3/11, 1927, to 3/13, 1927, that I last saw her alive on 3/13, 1927 and that death occurred, on the date stated above, at 10 45 a. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Acute Hypostatic Pneumonia (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes. Date of 3/11/27

Was there an autopsy? no

What test confirmed diagnosis? Clinical History

(Signed) Thomas H. Jenkins, M. D.

3/13, 1927 (Address) West Baltimore Gen. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery DATE OF BURIAL 3/16 1927

20 UNDERTAKER Chas F. Ernst & Son ADDRESS 1184 W. Royal ave

Spec.-7-17-26—A Co.—200 Blks.

E 20131

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 20131

## CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 802 S. Ann St., 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stanislaus Czyzewski

(a) RESIDENCE NO. 802 S Ann St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. da. How long in U. S. if of foreign birth? 4 yrs. mos. da.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced BUSBAND of (or) WIFE of Lena Czyzewski

6 DATE OF BIRTH (month, day, and year) Sept 13 1892

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min.. |
|---|---|---|---|---|
| | 34 | 6 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Poland

PARENTS

10 NAME OF FATHER Marion Czyzewski

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Lena Czyzewski

(Address) 802 S Ann St

Filed 1927 C. HAMPSON JONES, M. D.

Per ACB Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13 1927

17 I HEREBY CERTIFY, That I attended deceased from March 12 1927 to March 13 1927

that I last saw him alive on March 12 1927

and that death occurred, on the date stated above, at 2.30 P.M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

6 (duration) yrs. mos. 1 da.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 da.

18 Where was disease contracted

If not at place of death? — —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? By Exam

(Signed) Jno F C Blades M. D.

19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary March 17 1927

Date of Burial

30 UNDERTAKER John N Weber

ADDRESS 1803 Bank St

Spec.-7-17-26—A Co.—200 Bks.

E 20132

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20132

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of BALTIMORE: (No. 1216 S Clinton St., 26-1 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria C Humberg

(a) RESIDENCE NO. 1216 S Clinton St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S. if of foreign birth? 6 yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles B Humberg

6 DATE OF BIRTH (month, day, and year) Sept 6-1843

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min.. |
|---|---|---|---|---|
| | 83 yrs | 6 | 7 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) -

(c) Name of employer -

9 BIRTHPLACE (city or town) -

(State or country) Germany

PARENTS

10 NAME OF FATHER John N. Humberg

11 BIRTHPLACE OF FATHER (City or town) -

(State or country) Germany

12 MAIDEN NAME OF MOTHER Catharine Buhlenberg

13 BIRTHPLACE OF MOTHER (City or town) -

(State or country) Germany

14 Informant A C Humberg

(Address) 1216 S Clinton St

15 Filed 4 1927 C. HAMILTON JONES, M. D. Registrar

Per ARB

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/13/ 1927

17 I HEREBY CERTIFY, That I attended deceased from March 7th 1927 to March 13th 1927

that I last saw h-- alive on Mar 12th 1927

and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 7 da.

CONTRIBUTORY (Secondary) -

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death? -

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) DW Jones M. D.

3/13/ 1927 (Address) 1011 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Loudon Pk | 3 16 1927 |
| 20 UNDERTAKER H. W. Cook | ADDRESS 3012 Frankl Ave |

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20133 63 E 20133

## CERTIFICATE OF DEATH

1-PLACE OF DEATH University Hospital REGISTERED NO. 20-69

City of BALTIMORE: (No. 6 St. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Mellmann

(a) RESIDENCE NO. 2518 Bayd St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1903

7 AGE: Years 24 Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet Maker

(b) General natura of industry, business, or establishment in which employed (or employer) 014

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Carl Mellmann

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Koppe

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Dr. H. W. Hopple

(Address) 703 McKewin Ave.

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per AKH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from March 9. 19 27. to March 13. 19 27.

that I last saw h alive on March 13. 19 27.

and that death occurred, on the data stated above, at 3.00 A m.

The CAUSE OF DEATH* was as follows:

Addisons Disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Jacob R Johnson M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Arlington Hill Home de Jour Date of Burial Mar 15 19 27

20 UNDERTAKER J. M. Cook ADDRESS 527 E Monument

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20134 — E 20134

## CERTIFICATE OF DEATH

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. St Helena ave St. 70-36 Ward 10)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard Franklin Millard

(a) RESIDENCE NO. 302 St Helena Ave St. St Helena Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 30 1922

| 7 AGE | Years | Months | Days | IF LESS than 1 day ... hrs. or ... min.. |
|---|---|---|---|---|
| | 4 | 4 | 14 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Pa.
(State or country)

PARENTS

10 NAME OF FATHER Howard F. Millard

11 BIRTHPLACE OF FATHER (City or town) ?
(State or country) Penn

12 MAIDEN NAME OF MOTHER Blanche Hudnut

13 BIRTHPLACE OF MOTHER (city or town) Penn
(State or country)

14 Informant Howard F. Millard
(Address) 302 St Helena Ave

15 Filed 4 1927 C. HAMILTON JONES, M. D. Registrar
By —

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14 1927

17 I HEREBY CERTIFY, That I attended deceased from March 6, 1927, to March 14, 1927, that I last saw him alive on March 13, 1927, and that death occurred, on the date stated above, at 6:30 a m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ... yrs. ... mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) Kent C Hammond, M. D.

. 19 (Address) 92 Baltimore ave. St Helena

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Cedar Lawn | Mar 16 1927 |
| 20 UNDERTAKER | ADDRESS |
| Wm Cook | 522 St. ave |

Spec.–7-17-26—A Co.—200 Bks.

E 20135

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

White 532 E 22

90 E 20135

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1524 Johns St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Campion

(a) RESIDENCE NO. 1524 Johns St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|---|
| Black | 83 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Ireland

PARENTS

10 NAME OF FATHER James Campion

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Quinglan

13 BIRTHPLACE OF MOTHER (City or town)

(State or country) Ireland

14 Informant Mrs. William Beatty

(Address) 1524 Johns Street

FEB 4 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13th 19 27

17 I HEREBY CERTIFY, That I attended deceased from March 9, 1927, to March 13, 1927, that I last saw h[illegible] alive on March 13, 19 27 and that death occurred, on the date stated above, at 2:15 P.M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency
Myocarditis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Cystocolitis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Thos. F. Hurley M. D.

, 19 (Address) 532 E. 22nd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters Cemetery

Date of Burial 3/15 1927

20 UNDERTAKER William Cook

ADDRESS 502 E North Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

20136

## CERTIFICATE OF DEATH.

74 E 20136

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) Bank ave Fakelawn St. 25-12 (WARD)

2-FULL NAME Johanna E. Oster

(a) RESIDENCE (Usual place of abode) No. Bank ave Fakelawn St., WARD.

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Herman W. Oster

6 DATE OF BIRTH (month, day, and year): Feb 16 1875

7 AGE: Years 52 Months ns Days 26 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany.

10 NAME OF FATHER: unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant (Address): Herman Oster Fakelawn

15 Filed 4 1927 C. HAMPSON JONES, M. D. Registrar Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 14 1927

17 I HEREBY CERTIFY, That I attended deceased from March 13, 1927, to March 14, 1927, that I last saw her alive on March 13, 1927, and that death occurred, on the date stated above, at 3.20 a.m.

The CAUSE OF DEATH* was as follows:

Apopelxy.

(duration) ns yrs. ns mos. 8 hrs. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ns Date of

Was there an autopsy? ns

What test confirmed diagnosis? Blood from mouth

(Signed) Raymond J. Klaus. M. D.

March 14, 1927 (Address) Fakelawn

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: LOUDON-PARK Cemetery — DATE OF BURIAL: March 17 1927

20 UNDERTAKER: F.B. Wippert — ADDRESS: 1850 W Baltimore St

Spec.—12-9-25—A Co.—200 Bks.

E 20137

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 ✓ E 20137

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS 25-15 REGISTERED NO.

City of BALTIMORE: (No. [redacted] St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilbur Brown

(a) RESIDENCE NO. Cedar Hill Brooklyn - Md. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Negro | Married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1889

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 38 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Richard Brown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Ellen Williams

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14

Informant

(Address) Records

Filed ..... 19 ..... C. HARRISON JONES, M. D.

ART J 1924 [illegible] Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 1927

17

I HEREBY CERTIFY, That I attended deceased from February 7, 1927, to March 12, 1927, that I last saw him alive on March 11, 1927, and that death occurred, on the date stated above, at 12.20 A m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency

Chronic Myocarditis & Insufficiency

Genral anasarca

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. 1 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? genral & laboratory

(Signed) R. Hogan Smith, M. D.

March 14 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Williams Conn | 3-15 1927 |

20 UNDERTAKER John H. Toadvine ADDRESS 1027 Druid Hill

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

20138 — 4th E 20138

## CERTIFICATE OF DEATH

20138

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1103 Wilcox St., 10th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Kraft

(a) RESIDENCE NO. 1108 Wilcox St. 10 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: the late Amelia Kraft.

6 DATE OF BIRTH (month, day, and year): Sept. 9 1858

7 AGE — Years: 68 Months: 6 Days: 4 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Produce dealer 045

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER: John Kraft

11 BIRTHPLACE OF FATHER (City or town): Germany.

(State or country)

12 MAIDEN NAME OF MOTHER: Eva C. Dill

13 BIRTHPLACE OF MOTHER (city or town): Germany

(State or country)

14 Informant: Wm. Joseph E. Kraft.

(Address): 1103 Baker St

15 Filed MAR 15 1927 19 ..... C. HARRISON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 13 19 27

17 I HEREBY CERTIFY, That I attended deceased from Feb-11 , 1927 , to Mch 13 , 1927 ,

that I last saw him alive on Mch 12 , 1927 ,

and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

..... (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Bronchitis

..... (duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. Gill Hall M. D.

Mch 13 1927 (Address) 1631 E North Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — Date of Burial: March 16 1927

20 UNDERTAKER: Henry Horch & Son — ADDRESS: 1301 E Eager

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20139

## CERTIFICATE OF DEATH.

90

E 20139

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1648 Mullikin St., 6-9 Ward)

2-FULL NAME Frances Patterson

(a) RESIDENCE NO. 1648 Mullikin St St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred 4yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | col | widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alexander Patterson

6 DATE OF BIRTH (month, day, and year) Aug 3/1871

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 54 | 7 | 8 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 27

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) Balto., Md

10 NAME OF FATHER Danielson Patterson

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Md

PARENTS

12 MAIDEN NAME OF MOTHER Elizabeth Sandre

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Md

14 Informant Blanche Johnson (Daughter)

(Address) 1648 Mulliken St

Filed MAR 15 1927 HAMILTON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 Mar 11/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocarditis (chr)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) "Acute Indigestion"

(duration) yrs. mos. ds.

(Signed) J. Lee Voller M. D.

(Coroner)

3/13/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the state yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Perry Cemetery Date of Burial March 15 1927

UNDERTAKER Dutton Davis ADDRESS 316 N Eden St.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

20140

CERTIFICATE OF DEATH X 100-901 E 20140

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 618 N. Caroline St., 7-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gilbert L. Grinnell

(a) RESIDENCE NO. 618 N. Caroline St. Ward Kent Co. Md'

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 8 ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | colored | single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug. 19-1926

| 7 AGE | Years | Months | Days 24 | IF LESS than 1 day hrs. or min.. |
|---|---|---|---|---|
| | | 6 | 21 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Kent Co. Md.

(State or country)

PARENTS

10 NAME OF FATHER Vincent Grinnell

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Jackson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Sarah Jackson

(Address) 618 N Caroline St

15 Filed 5 1927 C. HARRISON JONES, M. D. Registrar

Per RR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 13 1927

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1927 to March 13, 1927.

that I last saw h live on March 12 1927.

and that death occurred, on the date stated above, at 3:20 a. m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

Primary

(duration) yrs. mos. 3 da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted

if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R L Gibney M. D.

3/14. 1927 (Address) 1424 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Georgetown Kent Co. Md.

Date of Burial Mar 15 1927

20 UNDERTAKER Chas. H. Johnson

ADDRESS 416 N. Carolina St.

Spec.-7-17-26—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 20141

## CERTIFICATE OF DEATH

E 20141

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 103 N Eden St. 5-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Viola Scott

(a) RESIDENCE NO. 103 N. Eden St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 21-1927

7 AGE: Years | Months | Days 22 21 | IF LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Wm. Scott

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Mable Scott

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Wm. Scott

(Address) 103 N Eden St

15 Filed ____, 19__ C. HAMILTON JONES, M. D. Registrar

5 1927 Per R M

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 5, 1927 to Mar 14 1927

that I last saw h in alive on Mar 12 1927

and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows: Bronchio-Pneumonia

(a)

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Bernard Ham, M. D.

. 19 (Address) 38 S Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ashbury Cemetery — Date of Burial: Mar 15 1927

20 UNDERTAKER: Chas. A. Johnson & Co. — ADDRESS: 1 N Caroline St

Cor.—1-12-23—M&T—100 Blks.

20142

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129 E 20142

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1009 Low ST., 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Patterson

(a) RESIDENCE NO. 1000 Low ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX: male

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced (write the word): widower

If married, widowed, or divorced HUSBAND of (or) WIFE of Clara Patterson

DATE OF BIRTH (month, day, and year) 1875

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 52 | 7 | 5 | |

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

BIRTHPLACE (city or town) (State or country): Atlanta Ga

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

Informant Emma Jennings

(Address) 319 Carlton St

Filed MAR 15 1927 H. TAYLOR JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 12 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mistake

Dont know.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Accidental fall

(duration) yrs. mos. ds.

(Signed) W J Fox, M. D. (Coroner)

Mar 13 1927 (Address) 1602 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Cemetery DATE OF BURIAL: Mar. 15 1927

UNDERTAKER: Elvie N. Johnson ADDRESS: 416 N. Carlton

Cor.—12-9-25—A Co.—200 Bks.

20143

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

100-001

E 20143

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St., 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Loretta Cangelose

(a) RESIDENCE NO. 500 Forrest St St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | white | single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) Dec 6/1923

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 3 | 3 | 7 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER John Cangelose

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Italy

12 MAIDEN NAME OF MOTHER Annetta Procato

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Italy

14 Informant John Cangelose

(Address) 503 [illegible]

15 Filed [illegible] Registrar

1 5 1927

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 13 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (Primary)

(Autopsy At Hopkins )

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) [signature] M. D.

(Coroner)

3/14/1927 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ..... mos., ..... ds. In the State ..... yrs., ..... mos., ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Holy Redeemer Cem. | 3/15 1927 |

20 UNDERTAKER Geo J Ruth ADDRESS 1735 Harford ave

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20144

## CERTIFICATE OF DEATH.

69 E 20144

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Johns Hopkins Hospital St. 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Abraham Pomerantz

(a) RESIDENCE NO. 2104 Orleans St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 4/26

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | | 5 | 10 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md

PARENTS

10 NAME OF FATHER Nathan Pomerantz

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Faga Levin

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Nathan Pomerantz

(Address) 2104 Orleans St

15 Filed APR 15 1927 C. HAMILTON JONES, M.

Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 14/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Purpura Simplex

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. Cullen M. D.
(Coroner)

3/14/27 (Address) 308 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dehgeu Rosedale Date of Burial 3/15 1927

20 UNDERTAKER Jack Lewis ADDRESS 439 E Balt St

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20145

## CERTIFICATE OF DEATH.

31 E 20145

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 417 N. Biddle St. 11-24 (WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Cooperstein

(a) RESIDENCE NO. 417 N. Biddle Street ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs mos da. How long in U. S., if of foreign birth? 20 yrs mos da

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced. (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Cooperstein

6b DATE OF BIRTH (month, day, and year): 1887

7 AGE: Years 40 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Untown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Untown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Yetta Cooperstein

(Address) 417 N. Biddle St.

Filed MAR 5 1927 CHARLES JONES, M. D. Registrar

Per R.L.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/14 1927

17 I HEREBY CERTIFY, That I attended deceased from 2/15 1927 to 3/13 1927.

that I last saw her alive on .. 1927,

and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary T. B.

(duration) 10 yrs. + mos — da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. J. Sudan M. D.

3/14 1927 (Address) 1918 E Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rehrer Workmen Cem Co | DATE OF BURIAL: 3/15 1927

20 UNDERTAKER: Jack Lewis | ADDRESS: 1439 E Baltimore

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20146

## CERTIFICATE OF DEATH

E 20146

1-PLACE OF DEATH

REGISTERED NO. 90

City of BALTIMORE: (No. 1821 W. Lexington St., 20-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Crockard,

(a) RESIDENCE NO. 1821 W. Lexington St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 78 yrs. 8 mos. — ds. How long in U. S. If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Christina L. Crockard,

6 DATE OF BIRTH (month, day, and year) July 14. 1848

| 7 AGE | Years | Months | Days | IF LESS than 1 day ... hrs. or ... min.. |
|---|---|---|---|---|
| | 78 | 8 | -- | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 604

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Gilmans School

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Crockard,

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Belfast. Ireland

12 MAIDEN NAME OF MOTHER Jane Dunn,

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Belfast. Ireland

14 Informant Mrs Christina L Crockard

(Address) 1821 W Lexington St

15 Filed MAR 15 1927 C. HAMPSON JONES, M. D. Registrar

Per R/C

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) MAR 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar. 14, 1927, to Mar 14, 1927, that I last saw h[illegible] alive on Mar 14, 1927, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

acute Dilatation of Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) Several yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Heart

(Signed) T. Labotte Ewell, M. D.

3/15, 1927 (Address) 2745 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

Date of Burial MAR 17 1927

20 UNDERTAKER Geo W Little

ADDRESS [illegible] Edmondson Ave.

Spec.—12-9-25—A Co.—200 Blks.

E 20147 HEALTH DEPARTMENT—CITY OF BALTIMORE E 20147

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Sinai Hospital REGISTERED NO. OK 129 J H Collins coroner

City of BALTIMORE: (No. ____ St. 6-9 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Schapiro

(a) RESIDENCE NO. 9 Irving Place St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? 40 yrs. — mos. — ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | white | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Solomon

6 DATE OF BIRTH (month, day, and year) Unknown.

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 64 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Russia (State or country)

PARENTS

10 NAME OF FATHER Samuel Myerowitz

11 BIRTHPLACE OF FATHER (city or town) Russia (State or country)

12 MAIDEN NAME OF MOTHER Sarah Uk.

13 BIRTHPLACE OF MOTHER (city or town) Russia (State or country)

14 Informant Solomon Schapiro (Address) 9 Irving Pl

Date MAR 15 1927 C. HAMILTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 14. 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar. 14th, 1927, to Mar. 14, 1927, that I last saw her alive on March 14, 1927, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Cardio-renal-vascular failure.

(duration) ____ yrs. 1 mos. ____ ds.

CONTRIBUTORY (Secondary) Hypertension - cardiac hypertrophy & dilatation

(duration) many yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of ____

Was there an autopsy? no

What test confirmed diagnosis? Clinical tests.

(Signed) C. Hamilton Jones, M. D.

3/14 1927 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Southern ave Date of Burial 3/15 1927

UNDERTAKER Solomon & Bro E Balto St ADDRESS 1127

Spec.–7-17-26—A Co.—200 Bks.

E 20148

# HEALTH DEPARTMENT—CITY OF BALTIMORE

11-002 E 20148

## CERTIFICATE OF DEATH

REGISTERED NO. _____

1-PLACE OF DEATH

City of BALTIMORE: (No. 1264 Exeter St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Brown

(a) RESIDENCE NO. 1264 Exeter St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S. if of foreign birth? 36 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hyman

6 DATE OF BIRTH (month, day, and year): Dec 1861

7 AGE: 65 Years 66 Months 3 Days — IF LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Meyer Rutterberg

11 BIRTHPLACE OF FATHER (City or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Eva Nik.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Sarah Brown (Address) 1264 Exeter St

15 Filed 15 1927 By _____ C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/14 19 27

17 I HEREBY CERTIFY, That I attended deceased from 3/13, 1927, to 3/13, 1927, that I last saw h[illegible] alive on [illegible], 19 27, and that death occurred, on the date stated above, at 2. P m.

The CAUSE OF DEATH* was as follows:

Lagrippe

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary): Old age

(duration) ____ yrs. ____ mos ____ ds.

18 Where was disease contracted

If not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) A. J. Rudow, M. D.

3/14, 1927 (Address) 918E, Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew-Rosedale — Date of Burial 3/15 1927

20 UNDERTAKER: [illegible] — ADDRESS 1127 E Baltimore

Spec.—12-9-25—A Co—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90

E 20149 REGISTERED NO. E 20149

E 20149 F DEATH

City of BALTIMORE: (No. 504 N. Eden St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas H. Smith

(a) RESIDENCE NO. 504 N. Eden St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | C. | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary C. Smith

6 DATE OF BIRTH (month, day, and year) autumn

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 70 yrs | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work laborer

(b) General nature of indastry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Mary C. Smith

(Address) 504 N. Eden St

15 Filed MAR 15 1927 C. HAMPTON JONES, M. D. Registrar

Per RH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 1927 to March 12 1927, that I last saw h[illegible] alive on March 12 1927, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Mitral [illegible] Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis and Hypertensive Complex

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) R. J. Young, M. D.

3-14-1927 (Address) 1426 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery Date of Burial 3/15 1927

20 UNDERTAKER Melchor H. Bailey ADDRESS 1425 E Monument

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129

FILED DEATH E 20150 REGISTERED E 20150

City of BALTIMORE: (No. 1334 Hellwood Ave St., 13-57 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida May Jones

(a) RESIDENCE NO. 1334 Hellwood Ave St. 13 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 23-1867

7 AGE: Years 59 | Months 6 | Days 20 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Laurel

(State or country) Md.

PARENTS

10 NAME OF FATHER Charles B. Jones

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Tabitha A. Tilson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant (Address) Miss Frances E. Jones 1334 Hellwood Ave

15 Filed 1927 19 HARRY JONES M D Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13 19 27.

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1926, to March 13, 1927, that I last saw h.. alive on March 13, 19 27, and that death occurred, on the date stated above, at 6 10 P. m.

The CAUSE OF DEATH* was as follows:

Anemia

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood smear (microscopic)

(Signed) Edwin J. Kelly, M. D.

(Address) 4 Dowrest Road

3/28/27

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Mary's (Hampden) Date of Burial March 16 19 27

20 UNDERTAKER: Horace M. Burgee ADDRESS 363 Falls Road.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 20151

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20151

## CERTIFICATE OF DEATH.

Registered No. .....

1-PLACE OF DEATH

City of BALTIMORE: (No.) 503 N. Monroe St., 21-24 (Ward) 161-08

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Uhler.

(a) Residence No. 503 N. Monroe St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, White.

5-Single, Married, or Divorced (Write the word.) Single.

6-If married, widowed, or divorced HUSBAND of (or) WIFE of no

7-DATE OF BIRTH (month, day and year) 3-14-27

8-AGE. ..... yrs. ..... mos. ..... ds. If LESS than 1 day. 6 hrs. or ..... min.?

9-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

10-BIRTHPLACE (city or town) (State or Country). 503 N. Monroe Balto Md

11-NAME OF FATHER Morris L. Uhler

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md

12-MAIDEN NAME OF MOTHER Viola L. Lucas.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) W. Va.

14-Informant Mrs. V. L. Uhler

(Address) 503 N. Monroe St

15-Filed MAR 15 1927 C. HAMPSON JONES, M. D., Registrar.

Per .....

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 3-14-27

17- I HEREBY CERTIFY, That I attended deceased from 3-14 1927 to 3-15 1927

that I last saw him alive on 3-14 1927

and that death occurred, on the date stated above, at 3.00a, m.

The CAUSE OF DEATH was as follows:

Premature Birth.

Ahout 7 mo.

6 hrs

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. R. Uhler M. D.

3/15/27 (Address) 2707 W. North

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Druid Ridge DATE OF BURIAL. Mar 15 1927

20-UNDERTAKER. Wm Cook ADDRESS 1507 E. North Ave

...c.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 20152

1-PLACE OF DEATH E 20152

CITY OF BALTIMORE: (No. 1906 E. Eager ST., 7-13 WARD)

REGISTERED NO. 161 E 20152

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Burns

(a) RESIDENCE NO. 1906 E. Eager ST., ..... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 0 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE Col.

5 Single, Married, Widowed, or Divorced, (write the word) Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) 3.12.27

| AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | | | | 1 |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ——

(b) General nature of industry, business, or establishment in which employed (or employer) ——

(c) Name of employer ——

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Manning Burns

11 BIRTHPLACE OF FATHER (city or town) (State or country) Anderson S.C.

12 MAIDEN NAME OF MOTHER Sandra Montgomery

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Danville Va.

Informant ——

(Address) ——

Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

Commissioner of Health

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3.12 1927

17 I HEREBY CERTIFY, That I attended deceased from 3.12, 1927, to 3.12, 1927,

that I last saw h— alive on 3.12, 1927,

and that death occurred, on the date stated above, at 9:30 a. m.

The CAUSE OF DEATH* was as follows:

Prematurity Birth

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Exp. Lab

(Signed) W. S. Baer, M. D.

, 19 (Address) 1500 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| HOPKINS HOSPITAL | 4 19 |
| 20 UNDERTAKER | ADDRESS |

JOHNS

Filed 4-5 1927 PS 115

nc.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20153 CERTIFICATE OF DEATH. × 3 E 20153

REGISTERED NO.

1-PLACE OF DEATH

ITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thelma Parker

(a) RESIDENCE No. Sycamore Ave - Sparrows Pt. Md WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Col | |

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) July - 1926

| AGE | Years | Months | Days | If LESS than 1 day, hrs or min |
|---|---|---|---|---|
| 8 mos. | | 8 | | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore
(State or country) Md

10 NAME OF FATHER Louis Parker

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Devine

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

Informant Records
(Address) JOHNS HOPKINS HOSPITAL

Filed MAR 5 1927, 19 H. HARRISON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5 1927

17

I HEREBY CERTIFY, That I attended deceased from 18 Feb. , 1927 , to 5 March , 1927 ,

that I last saw her alive on 5 March , 1927

and that death occurred, on the date stated above, at 2 a. m

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary) Rickets

(duration) yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? Sycamore Ave. Sparrows Pt

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. E. Handley , M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL 19 |
|---|---|
| 20 UNDERTAKER | ADDRESS |

JOHNS HOPKINS HOSPITAL MAR 14 1927

Baltimore City Health Department

ec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20154

E 20154

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

ITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 16-22/61 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mebidell Mattson

(a) RESIDENCE No. 1117 Bradley St ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | |

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year)

| AGE | Years | Months | Days | If LESS than 1 day, hrs or min |
|---|---|---|---|---|
| | | | 10 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work....

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md -

10 NAME OF FATHER Samuel Mattson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md -

12 MAIDEN NAME OF MOTHER Mamie Hebster

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md -

Informant Records - JOHNS HOPKINS HOSPITAL

(Address)

Filed MAR 15 1927 H. HANSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 8th 1927

17

I HEREBY CERTIFY, That I attended deceased from , 19 , to 19 ,

that I last saw h alive on , 19

and that death occurred, on the date stated above, at m

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs mos 10 ds

CONTRIBUTORY (Secondary)

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. D. Jones Harold Gorsuch M.D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| JOHNS HOPKINS HOSPITAL | MAR 14 1927 |

20 UNDERTAKER

ADDRESS

Commissioner Health,

Spec.—8-24-14—M. & T.—2000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20155 **CERTIFICATE OF DEATH.** 161-00 E 20155

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE: (No. 1501 N Bilfield St. WARD 8-1)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gwo Foster Lamb

(Residence in Baltimore: No. 1501 N Bilfield St. yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, 9 (Month) 11 (Day), 27 (Year)

7-AGE, ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, 12 hrs. or ..... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work: Infant (b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country), Md.

10-NAME OF FATHER, Thomas E Lamb

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Theresie Feeley

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs T E Lamb

(Address) 1501 N Bilfield St

Filed ....., 191... .....

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 3 (Month) 12 (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 3-11 1927, to 3-12 1927 that I saw h[illegible] alive on 3-11 1927 and that death occurred, on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Premature Birth

Atelectasis

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

3-14-27 (Address) 606 N Bilfield St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITAL — DATE OF BURIAL, ....., 191...

20-UNDERTAKER — ADDRESS

MAR 14 1927

MAR 15 1927 C. HAMPSON JONES, M. D. Commissioner of Health

1148

Spec.—8-24-14—M. & T.—2000 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20156 **CERTIFICATE OF DEATH.** 161-001 E 20156

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 627 E 31st St.; 9-47 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant (boy) Hardy

(Residence in Baltimore: No. St.; yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

DATE OF BIRTH, 3 (Month) — 10 (Day), 27 (Year)

AGE, 1 min. yrs. mos. ds.

If LESS than 1 day, hrs. or 1 min.?

7-OCCUPATION:
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)

8-BIRTHPLACE, (State or Country), Md.

10-NAME OF FATHER. J. M. Hardy

11-BIRTHPLACE OF FATHER (State or Country), Pa

12-MAIDEN NAME OF MOTHER C. Sanders

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. J. Hardy

(Address) 627 E 31st St

Filed MAR 15 1927, 191 C. HAMPSON JONES, M. D. Registrar.

1147

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 3 (Month) — 10 (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 3-10 1927 to 3-10 1927 that I saw h[e] alive on 3-10 1927 and that death occurred, on the date stated above, at 1 10 m.

The CAUSE OF DEATH* was as follows:

Intest Hemorrhage
due to Immaturity
Heart Failure
Birth

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Congenital Debility

(Duration) yrs. mos. 1 ds.

(Signed) Fred Pincoffs M. D.

3-10-27, 191 (Address) 800 N Patterson Pk

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, ..., 191...

20-UNDERTAKER ADDRESS

Commissioner Health. MAR 14 1927

UNIVERSITY OF MARYLAND

WM. K. WOODALL

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20157

## CERTIFICATE OF DEATH.

101-001

E 20157

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 934 E. Madison St St., 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marcus Williams

(a) RESIDENCE NO. 934 E.Madison St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: col

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Martha Williams

6 DATE OF BIRTH (month, day, and year): Aug 10/1898

7 AGE — Years: 28 — Months: 7 — Days: 1 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Western Md. Dairy

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): S.C

PARENTS

10 NAME OF FATHER: John Williams

11 BIRTHPLACE OF FATHER (city or town)

(State or country): S.C.

12 MAIDEN NAME OF MOTHER: Lula Kent

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): S.C.

14 Informant: Martha Williams

(Address): 934 E.Madison St

15 FILED MAR 15 1927 C. HARRY JONES, M. D. Registrar

Per

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 11/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Collins M. D.

(Coroner)

3/14/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Cemetery Date of Burial: Mar 16 1927

20 UNDERTAKER: Mrs. Ida Saunders ADDRESS: 1408 Madison

Spec.—12-9-25—A Co.—200 Blks.

E 20158

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

37-021

REGISTERED NO. E 20158

1-PLACE OF DEATH

City of BALTIMORE: (No. 2728 Pigg St., 16-68 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie augusta Ehrlich

(a) RESIDENCE NO. 2728 Pigg St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: f

4 Color or Race: w

5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 12-23-1905

7 AGE: Years 21 | Months 4 | Days 19 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer: Benjamin Perkins

9 BIRTHPLACE (city or town)

(State or country): Balto

10 NAME OF FATHER: Ruth a Ehrlich

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Ruth Dodge

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md

14 Informant: Ruth A. Ehrlich

(Address): 2313 Nunnery

Filed ..... 19..... C. HAMPSON JONES, M. D. Registrar

R 15152 Per K.K.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

3-12-27

17

I° HEREBY CERTIFY, That I attended deceased from Jan 27th, 1927, to March 12th, 1927,

that I last saw h.. alive on March 12th, 1927,

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Acute Miliary Tuberculosis

(duration) yrs. 1½ mos. ds.

CONTRIBUTORY (Secondary) ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray & Clinical

3/13, 1927 (Signed) Burn M'Cuen, M. D.

(Address) 400 N Payson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery Date of Burial: March 15 1927

20 UNDERTAKER: George J. Ruth ADDRESS: 1735 Harford Av

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20159

100-001

## CERTIFICATE OF DEATH.

REGISTERED NO. E 20159

1-PLACE OF DEATH

City of BALTIMORE: (No. 9 E. Henrietta St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Osbourne E. Hoffman

(a) RESIDENCE NO. 9 E. Bennett St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 4th, 1916

7 AGE — Years: — Months: 11 Days: 10 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town): City

(State or country)

10 NAME OF FATHER: Louis Hoffman

11 BIRTHPLACE OF FATHER (city or town)

(State or country): City

12 MAIDEN NAME OF MOTHER: Carrie Kinnamon

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): City.

14 Informant: Mrs. Louis Hoffman

(Address) 9 E. Bennett St.

Filed MAR 15 1927 [illegible] Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 14th 1927

17

I HEREBY CERTIFY, That I attended deceased from March 1, 1927, to March 14, 1927, that I last saw him alive on March 13, 1927, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia. (Coma)

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Henry F. Buettner, M. D.

, 19 (Address) 1319 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery Date of Burial 3/15 1927

20 UNDERTAKER: E. J. Fanning ADDRESS: Son - 1386 Lafayette Av.

Spec.—1-10-21—M&T—1500 Bks.

E 20160

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20160

## CERTIFICATE OF DEATH.

REGISTERED NO. 27-53 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1737 N. Broadway St. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Crever Clayton

(a) RESIDENCE No. 210 Hawthorn Rd St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

DATE OF BIRTH (month, day, and year) Sept 16-1855

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 71 | 5 | 26 da | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. Ofd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER John T. Clayton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Annapolis Md.

12 MAIDEN NAME OF MOTHER Jane Elliott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

Informant Wm E. Clayton

(Address) 210 Hawthorn Rd.

Filed MAR 15 1927 HARRISON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-14- 1927.

17 I HEREBY CERTIFY, That I attended deceased from 3-8- 1927, to 3-14- 1927.

that I last saw her alive on 3-13- 1927.

and that death occurred, on the date stated above, at 12:10 A. m.

The CAUSE OF DEATH* was as follows:

Influenza.

(duration) — yrs. — mos 9 ds.

CONTRIBUTORY (Secondary) Organic Heart Disease

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? physical signs

(Signed) Chester Riland, M. D.

3-14-1927 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: March 16 1927

20 UNDERTAKER: John B. Spence — ADDRESS: 1328 N Caroline St

20161 — A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20161

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. 12-49

City of BALTIMORE: (No. Union Memorial Hospital (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Philip O Stewart

(a) RESIDENCE NO. Prospect, Kentucky St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 18 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | Married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mrs Philip O Stewart

6 DATE OF BIRTH (month, day, and year)
Jan 11, 1861

| 7 AGE | Years | Months | Days | IF LESS than 1 day ...hrs. or ...min.. |
|---|---|---|---|---|
| | 66 | 2 | 3 | |

8 OCCUPATION OF DEECEASED
(a) Trade, profession or particular kind of work Retired - 000
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Kentucky

PARENTS

10 NAME OF FATHER J. J. Stewart

11 BIRTHPLACE OF FATHER (City or town)
(State or country) Ky.

12 MAIDEN NAME OF MOTHER Mary Barbour

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ky.

14 Informant Mrs. P. O Stewart
(Address) Prospect Kentucky

15 Filed ..... 19 .....
5 1927 C. HA... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19
Mar 14. 1927

17 I HEREBY CERTIFY, That I attended deceased from
Feb 25 19 27, to Mar 14 19 27.
that I last saw h... alive on Mar 14 19 27.
and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:
Cancer of the Stomach
(duration) yrs. 8 mos. ds.
CONTRIBUTORY (Secondary) Pneumonia
(duration) yrs. mos. 10 ds.

18 Where was disease contracted
If not at place of death?
Did an operation precede death? Yes Date of Mar 1 1927
Was there an autopsy? No
What test confirmed diagnosis? Operation

(Signed) J. R. Bruce, M. D.
, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
Louisville Kentucky
Date of Burial March 15 192...

20 UNDERTAKER
Henry Jenkins & Co
ADDRESS

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20162

## CERTIFICATE OF DEATH.

1 PLACE OF DEATH E 20162

REGISTERED NO. 90

CITY OF BALTIMORE: (No. 1225 Ethring St. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joshua Mordell

(a) RESIDENCE NO. 1925 Ethring ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male. | Colored | Single |

6 If married, widowed, or divorced HUSBAND of (or) WIFE of —

DATE OF BIRTH (month, day, and year) 1874

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| 77 | 73. | | | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter 070

(b) General nature of industry, business, or establishment in which employed (or employer) Store

(c) Name of employer Bourgeois Store

BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Joshua Mordell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Eliza Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Paul McCully

(Address) 1707 Ethring St

Filed OCT 5 1927 H. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 4, 1927

17 I HEREBY CERTIFY, That I attended deceased from October 4th 1927. to October 4th 1927.

that I last saw h— alive on October 1st 1927

and that death occurred, on the date stated above, at 3:47 P. m.

The CAUSE OF DEATH* was as follows: Myocarditis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) H. Lee Elliott, M. D.

(Address) 1st Medical

Oct 5 1927

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL Nov. 15 1927

20 UNDERTAKER J. W. M. Johnson

ADDRESS 1234 Ethring St.

Cor.—12-9-25—A Co.—200 Bks. Pauline Daukschuck.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

188-003

20163

## CERTIFICATE OF DEATH.

E 20163

REGISTERED NO.

1-PLACE OF DEATH Premises Green & Lombard 4-30

City of BALTIMORE: (No. ~~219 N Lombard~~ St. 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Pauline Daukschuck

(a) RESIDENCE NO. 519 N Lombard St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. — mos. ds. How long in U. S., if of foreign birth? 12 yrs. — mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F. | W | married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of not known

6 DATE OF BIRTH (month, day, and year)
12 8 0

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 47 | | | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tailor 08
(b) General nature of industry, business, or establishment in which employed (or employer) not known
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Lithuania

PARENTS

10 NAME OF FATHER John Jusfules

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Lithuania

12 MAIDEN NAME OF MOTHER Anna Durban

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Lithuania

14 Informant Joseph Daugaptis
(Address) 819 N Lombard St.

15 Filed MAR 15 1927 C. HARRISON JONES, M. D. Registrar
Per

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/12/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Automobile accident
Struck while crossing street
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Fracture of L. Femur
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Paul J. Krahn M. D.
(Coroner)

, 19 27 (Address) 3325 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs., .....mos., .....ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — Date of Burial March 16 1927

20 UNDERTAKER John Grebliunckas — ADDRESS 423 S. Paca St.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20164

## CERTIFICATE OF DEATH.

170 E 20164

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hospital 14-54 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michael House

(a) RESIDENCE NO. 503 Cumberland St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine House

6 DATE OF BIRTH (month, day, and year) March 11, 1847

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 80 | 0 | 3 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Jeweler 038

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) _____ (State or country) Canada

PARENTS

10 NAME OF FATHER George House

11 BIRTHPLACE OF FATHER (city or town) _____ (State or country) Canada

12 MAIDEN NAME OF MOTHER Mary Mennegde

13 BIRTHPLACE OF MOTHER (city or town) _____ (State or country) Canada

14 Informant Catherine House

(Address) 503 Cumberland St

15 Filed 1927 C. HAMPSON JONES, M. D., Registrar

Per _____

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by gun-shot wound in head about 1½ hrs. (Pistol) (duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) _____ (duration) ____ yrs. ____ mos. ____ ds.

(Signed) D. T. Hennessy M. D. (Coroner)

March 15, 1927 (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Date of Burial March 19 27

20 UNDERTAKER Joseph Lefler ADDRESS 1600 N. Howard

Spec.—12-9-25—A Co.—200 Bks.

E 20165

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20165

## CERTIFICATE OF DEATH.

REGISTERED NO. 1-20 31

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. (or B.) Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Moore (Wood)

(a) RESIDENCE NO. 555 Mosher st. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | Colored | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1890 ?

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 37 ? | | | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cook
(b) General nature of industry, business, or establishment in which employed (or employer) Resturant
(c) Name of employer Unknown

9 BIRTHPLACE (city or town)
(State or country) Georgia

10 NAME OF FATHER William Wood

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Georgia

12 MAIDEN NAME OF MOTHER Mary Starks

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Georgia

PARENTS

14 Informant Hospital Records
(Address)

Filed ..... 19 ..... C. HAMPSON JONES, M. D.
Registrar

5 1927 1150

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12, 1927 19

17
I HEREBY CERTIFY, That I attended deceased from March 2, 1927, to March 12, 1927,
that I last saw him alive on March 12, 1927,
and that death occurred, on the date stated above, at 12.05a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) Unknown mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted Unknown
If not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) W. Gatting, M. D.
3-12, 27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

Commissioner Health

UNIVERSITY OF MARYLAND

MAR 15 1927

Spec.—12-9-25—A Co.—200 Pks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20166

E 20166

136

## CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) Balto City Hospitals (St.) 17-23 (Ward)

2-FULL NAME John Hall

(a) RESIDENCE NO. 920 Pennsylvania Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced (write the word): Single

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1909

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 18 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Labors

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country)

10 NAME OF FATHER Edward Hall

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mamie

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) New Jersey

14 Informant

(Address)

15 1927 C. HANSON JONES, M. D. Registrar

1158 Rch

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

March 12, 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan. 15, 1927, to March 12, 1927

that I last saw him alive on March 12, 1927

and that death occurred, on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia Septicemia

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Septicemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Culture

(Signed) C. Hanson Jones M. D.

, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial 19

20 UNDERTAKER

ADDRESS

Comm'r of Health

UNIVERSITY OF MARYLAND

MAR 15 1927

Spec.—12-9-25—A Co.—200 Bks.

E 20167

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20167

## CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St., 7-17 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Huber

(a) RESIDENCE NO. 1814 E. Biddle St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 4 mos. ? ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Single? |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1886 - October Date ?

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 40 | 4 5 | ? | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 04D

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

10 NAME OF FATHER Fred Huber

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Susanna ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

PARENTS

14 Informant Hospital Records

(Address)

15 Filed 1927 C. HAMPSON JONES, M. D. Per Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-12 1927

17

I HEREBY CERTIFY, That I attended deceased from 1-11 1927, to 3-12, 1927, that I last saw him alive on March 12, 1927, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Bilateral Pulmonary Tuberculosis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

None (duration) None yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of None

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical findings and autopsy

(Signed) J. C. Battem, M. D.

, 19 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery Date of Burial Mar 14 27

20 UNDERTAKER John Merrick ADDRESS 908 Orleans

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20168

E 20168

## CERTIFICATE OF DEATH

90

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 2012 Bolton St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Elley Little

(a) RESIDENCE NO. 2012 Bolton St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 11, 1843

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 84 | 2 | 3 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Hagerstown (State or country) Md

PARENTS

10 NAME OF FATHER Alexander McLanmon

11 BIRTHPLACE OF FATHER (City or town) Hagerstown (State or country) Md

12 MAIDEN NAME OF MOTHER Susan Mottag

13 BIRTHPLACE OF MOTHER (city or town) Hagerstown (State or country)

14 Informant H. H. Little (Address) 2012 Bolton St

15 Filed 1927 C. HARRISON JONES, M. D. Registrar Per ARC

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 March 14, 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 1, 19 27, to 3/14, 19 27

that I last saw her alive on 3/13, 19 27

and that death occurred, on the date stated above, at 6 40 a.m.

The CAUSE OF DEATH* was as follows:

Chronic valvular Heart

(duration) many yrs mos days

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? X Date of

Was there an autopsy? X

What test confirmed diagnosis? clinical

(Signed) Leverett, M. D.

3/15 19 27 (Address) 2012 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hagerstown Md — Date of Burial March 16 19 27

20 UNDERTAKER George J. Smith — ADDRESS 1532 Holliday St

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20169 ✓ 102 E 20169

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St. [redacted] Ward) 4th

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Appleby

(a) RESIDENCE NO. 611 West Baltimore St. _____ Ward _____

(Usual place of abode) Unknown (If non-resident give city or town and State)

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widowed |

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1860

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 67 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) 463

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) New Jersey

PARENTS

10 NAME OF FATHER William Appleby

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) New Jersey

12 MAIDEN NAME OF MOTHER Louisa Perine

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Pima

14 Informant BALTIMORE CITY HOSPITALS

(Address) [redacted] Records

15 Filed 1927 C. HAMPSON JONES, M. D.

Per _____ Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 1927

17

I HEREBY CERTIFY, That I attended deceased from March 7 1927, to March 12, 1927, that I last saw him alive on March 12, 1927, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia
Fibrinous Pleurisy

(duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY _____
(Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted

If not at place of death? _____

Did an operation precede death? no Date of _____

Was there an autopsy? yes

What test confirmed diagnosis? Clinical Laboratory

(Signed) R. Hoopes Smith, M. D.

March 15 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Sacred Heart | 3/15 1927 |

20 UNDERTAKER D. J. Daly Son ADDRESS 318 Light St

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20170

101-001

## CERTIFICATE OF DEATH.

E 20170

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH South Balt. Hospital

City of BALTIMORE: (No. 1413 S. Light St. 8-17 Ward)

2-FULL NAME Miss Christina Schenfler

(a) RESIDENCE NO. 1764 E. North ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 1 1869

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 58 | 0 | 14 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER John Schenfler

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Lena Kerr

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Clifton C. Schenfler

(Address) 4313 Buck Road

15 1927 C. HAMPSON JONES, M. D.

Per Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

March 15, 1927

17

I HEREBY CERTIFY, That I attended deceased from March 3, 19 27, to March 15, 19 27, that I last saw h alive on March 15, 19 27, and that death occurred, on the date stated above, at 1 m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. B. Miller, M. D.

, 19 (Address) South Balt. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Woodlawn Cemetery | Mar 17 1927 |
| **20 UNDERTAKER** | **ADDRESS** |
| Henry Sander & Sons Inc | 1710 East St |

Spec.—12-9-25—A Co.—200 Bks.

20171

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

100-001

E 20171

L20-69

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 573 Millington Ward)

2-FULL NAME Barbara Heinberg

(a) RESIDENCE NO. 573 Millington St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? 38 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 8th. 1852

7 AGE: Years 74 | Months 9 | Days 5 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) France

10 NAME OF FATHER John Heinberg

11 BIRTHPLACE OF FATHER (city or town):

(State or country) France

12 MAIDEN NAME OF MOTHER Christina Florin

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) France

14 Informant Hyman Rosenberg

(Address) 573 Millington St

15 C. HAMPSON JONES, M. D.

1927 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927

March 13

17 I HEREBY CERTIFY, That I attended deceased from March 4 1927, to March 13, 1927, that I last saw h[er] alive on March 13, 1927, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia (a)

(duration) .....yrs. .....mos. 9 ds.

CONTRIBUTORY (Secondary) Oedema of lungs Cardiac Dilatation

(duration) .....yrs. .....mos. 2 ds.

18 Where was disease contracted at home

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Joseph E. Fisher, M. D.

19 (Address) 3101 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — Date of Burial: Mch 16 1927

20 UNDERTAKER: Robt. T. Turner — ADDRESS: 1442 N. Broadway Baltimore Md.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20172

CERTIFICATE OF DEATH.

90 E 20172

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE (No. 1419 E. Lafayette Ave St., 9-17 Ward)

2-FULL NAME Helen Morris

(a) RESIDENCE NO. 1419 E. Lafayette Ave St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. dy. How long in U. S., if at foreign birth? Life yrs. mos. dy.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: None

6 DATE OF BIRTH (month, day, and year): 11/14/1916

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 10 | 4 | 0 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Baltimore, Md.

10 NAME OF FATHER Wm. W. Morris

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Sarah O'Brien

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Baltimore Md.

14 Informant William W. Morris

(Address) 1419 E. Lafayette Ave

MAR 15 1927

C. HAMILTON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 14 1927

17 I HEREBY CERTIFY, That I attended deceased from March 7, 1927, to March 14, 1927, that I last saw her alive on March 14, 1927 and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Bilateral Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Chronic Valvular disease of Heart (duration) 2 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jethro Gaudron M. D.

3/15, 1927 (Address) 1714 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery

Date of Burial: 3/16 1927

20 UNDERTAKER: George J. Ruth

ADDRESS: 1735 Harford Ave

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20173

## CERTIFICATE OF DEATH.

2575 139 E 20173

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore General Hospital ST. WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Schweiger.

(a) RESIDENCE NO. 106 S. 6th St. Brooklyn. ST. WARD
(Usual place of abode)
Length of residence in city or town where death occurred 42 yrs. 11 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female.

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced, (write the word): Married.

6 If married, widowed, or divorced
(of) HUSBAND OF
(or) WIFE of Adam Schweiger.

7 DATE OF BIRTH (month, day, and year) March 19, 1884

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 42 | 11 | 21 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

10 NAME OF FATHER: Patrick Lennon.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland.

12 MAIDEN NAME OF MOTHER: Josephine Ackers.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore, Md.

14 Informant (Address): Adam Schweiger. (husband) 108 S. 6th St. Brooklyn.

15 1927 C. HAMPSON JONES, M. D. Registrar
Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 1927

17 I HEREBY CERTIFY, That I attended deceased from March 12, 1927, to March 12, 1927, that I last saw her alive on March 12, 1927, and that death occurred, on the date stated above, at 5.30 P.m.

The CAUSE OF DEATH* was as follows:

Cardiac failure
Myocarditis

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Operation.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? Yes Date of March 12/27.

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) H. McClel, M. D.

, 19 (Address) South Baltimore Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Mar 16/27

20 UNDERTAKER: Chas A. Moran — ADDRESS: 3000 E. Balto St. Balto Md.

Inquest received Dec 10 in Reinhardt's office

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

20174

## CERTIFICATE OF DEATH.

166 E 20174

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Holkins Hospital St., 1-2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ida Horney

(a) RESIDENCE NO. 19 S. Hare St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John T. Horney

6 DATE OF BIRTH (month, day, and year): 1866

7 AGE — Years: 61 — Months: — Days: — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Unknown

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Balto., Md.

(State or country)

10 NAME OF FATHER: John Frawley

11 BIRTHPLACE OF FATHER (city or town): Ireland

(State or country)

12 MAIDEN NAME OF MOTHER: Mary Allen

13 BIRTHPLACE OF MOTHER (city or town): Ireland

(State or country)

14 Informant: Gordon Horney (son)

(Address): 19 S. Hare St

15 1927 C. HAMPSON JONES, M. D.

Registrar

Per

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 13/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bichloride Mercury Poisoning

Suicide.

(Autopsy at Hopkins)

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) J. H. Keller M. D.

(Coroner)

3/13/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ....mos., ....ds. In the State ....yrs., ....mos., ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Patrick's Cem. Date of Burial: 3/16 1927

20 UNDERTAKER: John A. Inman ADDRESS: 3011 E. N. Ave

Spec.—1-10-21—M&T—1500 Bks.

20175

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20175

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 9 Cole ave. ST. Raspeburg WARD) 26-42

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Emma Bell

(a) RESIDENCE NO. 9 Cole ave. Raspeburg ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) July 25th 1923

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 3 | 7 | 20 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Balto. Md.

10 NAME OF FATHER: Howard M. Bell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Maryland

12 MAIDEN NAME OF MOTHER: Emma Biggins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Maryland

Informant: Howard M. Bell

(Address) 9 Cole Ave. Raspeburg

1927 C. HAMPSON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14 1927

17 I HEREBY CERTIFY, That I attended deceased from March 4, 1927, to March 14, 1927, that I last saw h alive on March 13, 1927, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw D Stone M. D.

3/14 1927 (Address) Cor Fr & Southern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cmetery — DATE OF BURIAL: March 17 1927

20 UNDERTAKER: Frederick Lissahm — ADDRESS: Fulberton

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20176 E 20176

## CERTIFICATE OF DEATH.

REGISTERED NO. 436 1001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 109 Valley Road ST., Hamilton WARD)

2-FULL NAME Aaron Frank Grace

(a) RESIDENCE No. 109 Valley Road ST., Hamilton WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Grace

DATE OF BIRTH (month, day, and year) Feb. 28th 1866

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 61 | — | 16 14 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Crook, Fick & Co.

BIRTHPLACE (city or town) (State or country) Baltimore Co. Md

10 NAME OF FATHER James S. Grace

11 BIRTHPLACE OF FATHER (city or town) Sussex Co. (State or country) Delaware

12 MAIDEN NAME OF MOTHER Charlotte Hoffman

13 BIRTHPLACE OF MOTHER (city or town) Hagerstown (State or country) New Jersey

Informant Mrs. Lena Grace

(Address) 109 Valley Road Hamilton

Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14th 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 7 1927 to March 14 1927

that I last saw h/ alive on March 14 1927

and that death occurred, on the date stated above, at 1:45 a. m.

The CAUSE OF DEATH* was as follows:

Uraemia

Parenchymatous

Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Secondary Anaemia + Neurasthenia (Probably Uraemic) Hours to Feb 7 days

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas Jones, M. D.

3/14/1927 (Address) 4700 Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| London Park Cemetery | March 16 1927 |
| 20 UNDERTAKER | ADDRESS |
| Frederick Lassahn & Son | Fulberton |

Spec.—12-9-25—A Co.—200 Bks.

E 20177

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20177

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St. 26-37 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isaac Nelson

(a) RESIDENCE NO. Washington - D.C. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Negro | ? |

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1871

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 56 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labour

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Washington

(State or country) D.C.

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant

(Address) Records

15 1927 C. HAMPSON JONES, M. D.

Per Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 1927

17 I HEREBY CERTIFY, That I attended deceased from November 26, 1926, to March 12, 1927, that I last saw him alive on March 12, 1927, and that death occurred, on the date stated above, at 11 15 P m.

The CAUSE OF DEATH* was as follows:

Cortical Sclerosis
Hypertension ?
(duration) yrs. mos. ds.

CONTRIBUTORY Bronchopneumonia
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? general & laboratory

(Signed) R Hoopes Smith, M. D.

Mch 15 1927 (Address) [redacted]

BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Washington D C Mar 15 1927

20 UNDERTAKER — ADDRESS

Robert F Millican 1515 N Eden St

Spec.–7-17-26—A Co.—200 Bks.

Van Williams—1601 N. Collington

E 20178

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 20178

## CERTIFICATE OF DEATH

1-PLACE OF DEATH 1713 N. Callington Ave REGISTERED NO.

City of BALTIMORE: (No. ) St., 8-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva M. Livingston

(a) RESIDENCE NO. 1713 N. Callington St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Wm. J. Livingston

6 DATE OF BIRTH (month, day, and year) Nov. 20, 1890

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min.. |
|---|---|---|---|---|
| | 36 | 3 | 24 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER Frank Sommers

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Catherine Hughes

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant Wm. J. Livingston

(Address) 1713 N. Callington Ave

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 6, 1927, to Mar 14, 1927, that I last saw he alive on Mar 12, 1927, and that death occurred, on the date stated above, at 1145 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) X yrs. X mos. 9 ds.

CONTRIBUTORY (Secondary) X

X (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? no Date of X

Was there an autopsy? no

What test confirmed diagnosis? Sputum, Culture

(Signed) W. Kimmell Williams, M. D.

, 19 (Address) 601 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Bloom, Accomac, Va | 3/16 1927 |
| 20 UNDERTAKER Wm. Cook | ADDRESS 500 E Mont |

Spec.—12-9-25—A Co.—200 Bks.

E 20179

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

49 E 20179

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. 21-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William A. Jones

(a) RESIDENCE NO. 742 Foundry Court St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1875

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 51 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

10 NAME OF FATHER George A. Jones

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Margaret E. Turner

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

PARENTS

14 Informant (Address) Hospital Records

15 Filed 1927 19 C. HAMPSON JONES, M. D., Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14, 1927

17

I HEREBY CERTIFY, That I attended deceased from January 6 19 27, to March 14 19 27,

that I last saw him alive on March 14, 19 27,

and that death occurred, on the date stated above, at 4.45 A m.

The CAUSE OF DEATH* was as follows:

Neoplasm of Lungs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death! Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

3-14-27 (Signed) W. E. Gallagher, M. D.

(Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — Date of Burial 3/17 1927

20 UNDERTAKER Anderson Coal — ADDRESS 5018 North

Spec.—1-10-21—M&T—1500 Bks.

E 20180

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20180

## CERTIFICATE OF DEATH.

13-54 101-801

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1578 Clifton ave ST.) (13 WARD)

2-FULL NAME Barrie Virginia Stout

(a) RESIDENCE NO. 1578 Clifton ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | W | Widow |

a If married, widowed, or divorced HUSBAND of (or) WIFE of George W Stout

DATE OF BIRTH (month, day, and year) March 17, 1852

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or ... min. |
|---|---|---|---|---|
| | 74 | 11 | 27 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Elias E Baugh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rachel Plowman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Elsie Shaemaker

(Address) 1554 Clifton ave

1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14 1927

17

I HEREBY CERTIFY, That I attended deceased from March 10, 1927, to March 14, 1927, that I last saw h[er] alive on March 14, 1927, and that death occurred, on the date stated above, at 10.40 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Fred C Jewett, M. D.

, 19 (Address) 2516 Penna ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 3/17 1927

20 UNDERTAKER William Cook

ADDRESS 502 E North Ave

Spec.–7-17-26—A Co.—200 Bks.

20181

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

90 E 20181

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 2207 Poplar Grove St St., 15-60 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia E. Cooper

(a) RESIDENCE NO. 2207 Poplar Grove St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Divorced |

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: Horace S. Cooper

6 DATE OF BIRTH (month, day, and year): March 17, 1880

| 7 AGE | Years | Months | Days | IF LESS than 1 day ... hrs. or ... min. |
|---|---|---|---|---|
| | 46 | 11 | 28 26 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer

9 BIRTHPLACE (city or town) ...

(State or country): Virginia

PARENTS

10 NAME OF FATHER: A. B. Cottrell

11 BIRTHPLACE OF FATHER (City or town) ...

(State or country): Virginia

12 MAIDEN NAME OF MOTHER: Alice V. Duvall

13 BIRTHPLACE OF MOTHER (city or town) ...

(State or country): Virginia

14 Informant: William H. Bass

(Address): 2207 Poplar Grove St.

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

By ...

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

March 15, 1927

17 I HEREBY CERTIFY, That I attended deceased from 3-8, 1927, to 3-14, 1927

that I last saw her alive on 3-14, 1927

and that death occurred, on the date stated above, at 6.42 a m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Mitral Insufficiency

Dilatation & Hypertrophy

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pachymeningitis Edema

(duration) yrs. mos 7 ds.

18 Where was disease contracted

If not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings.

(Signed) W. H. Thomas, M. D.

(Address) 1403 Park Avenue

3-15-1927

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Richmond, Va | March 16 1927 |
| 20 UNDERTAKER: Capell & Cook | ADDRESS: 1003 N Gilmore St |

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20182

CERTIFICATE OF DEATH.

E 20182

REGISTERED NO._____

1-PLACE OF DEATH John Hopkins Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of BALTIMORE: (No._____ St., 7-9 Ward)

2-FULL NAME William H. Mowerson

(a) RESIDENCE NO. Tenafly, New Jersey St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): ~~single~~ married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lavinia Westervelt

6 DATE OF BIRTH (month, day, and year): Aug. , 1857

7 AGE: Years 69; Months 7; Days; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Coal operator

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) New Jersey

PARENTS

10 NAME OF FATHER ----

11 BIRTHPLACE OF FATHER (city or town):

(State or country) ---

12 MAIDEN NAME OF MOTHER ----

13 BIRTHPLACE OF MOTHER (city or town):

(State or country)

14 Informant: Harry W. Mowerson

(Address) Tenafly, New Jersey

1927 C. HAMPSON JONES, M. D., Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 15th 27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pyonephritis (rt side)

(Autopsy at Hospital)

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Carcinoma of Urinary bladder

(duration) ....yrs. ....mos. ....ds.

(Signed) J. T. H. Patton, M. D.

(Coroner)

3/15/27 (Address) 508 E. Nprth Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Tenafly, N. J. Date of Burial: Mar. 17, 19 27

20 UNDERTAKER: ~~1900 Eutaw Place~~ John O. Mitchell ADDRESS 1900 Eutaw Pl.

Spec.—12-9-25—A Co.—200 Blks.

D 20183

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

X 124 E 20183

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

City of BALTIMORE: (No. ____ St., 7-9 (Ward)

REGISTERED NO. ____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Innis

(a) RESIDENCE NO. Locke Rason Mdst. Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. mos. 11 ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary

6 DATE OF BIRTH (month, day, and year) unknown.

| 7 AGE | Years | Months | Days | IF LESS than 1 day ____hrs. or ____min. |
|---|---|---|---|---|
| | 61 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farm Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ____

(c) Name of employer ____

9 BIRTHPLACE (city or town) Md —

(State or country)

PARENTS

10 NAME OF FATHER Henry Innis

11 BIRTHPLACE OF FATHER (city or town) Md —

(State or country)

12 MAIDEN NAME OF MOTHER Caroline Elizabeth

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Records —

(Address) JOHNS HOPKINS HOSPITAL

Filed MAR 16 1927 Per ____ Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14 1927

17 I HEREBY CERTIFY, That I attended deceased from March 3, 1927, to March 14, 1927, that I last saw him alive on March 14, 1927, and that death occurred, on the date stated above, at 5:25 a. m.

The CAUSE OF DEATH* was as follows:

Emphysema (right chest)

? (duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) ____

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of March 10 1927

Was there an autopsy? yes

What test confirmed diagnosis? ( )

(Signed) Henry A. Coleman, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pleasant Rest Towson Date of Burial March 16-27

20 UNDERTAKER John T. Burns Sons ADDRESS Towson

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20184

## CERTIFICATE OF DEATH.

E 20184
REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2314 Etting st ST., 14-59 WARD)

2-FULL NAME Elizabeth Thomas

(a) RESIDENCE NO. 2314 Etting ST., ..... WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX: Female
4 COLOR OR RACE: Colored
5 Single, Married, Widowed, or Divorced, (write the word): married

If married, widowed, or divorced HUSBAND of (or) WIFE of: John Thomas

DATE OF BIRTH (month, day, and year): Mar 1862

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| 65 | — | — | — | |

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laundress
(b) General nature of Industry, business, or establishment in which employed (or employer): 041
(c) Name of employer

BIRTHPLACE (city or town) (State or country): Md.

10 NAME OF FATHER: John Dorsey
11 BIRTHPLACE OF FATHER (city or town) (State or country): Md
12 MAIDEN NAME OF MOTHER: Millie Grant
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

Informant: Hannah Skinner
(Address) 2316 Etting st

Filed MAR 16 1927 19.. H. A. JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 14th 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 8th 1927 to Mar 14 1927.
that I last saw h[illegible] alive on Mar 14 1927.
and that death occurred, on the date stated above, at 11-20 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Cerebral Arteriosclerosis

(duration) yrs. — mos. 7 ds.

18 Where was disease contracted if not at place of death? unknown.
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) Harriet Brown M. D.
(Address) 1916 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: March 16th 1927

20 UNDERTAKER: Emmert & Wright — ADDRESS: 1364 Mass

Spec.—1-10-21—M&T—1500 Blks.

20185

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

38 E 20185

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 518 Wellcome St.) (Ward) 22-30

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Pierce

(a) RESIDENCE NO. 518 Wellcome St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | Infant |

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) March 12 '27

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | | | 3 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... 0 0

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Maryland

10 NAME OF FATHER Wm. Ewin Whitte

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Cora Pierce

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Cora Pierce

(Address) 518 Wellcome Alley

15 MAR 16 1927 HAMPTON JONES, M. D. (Registrar)

By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15th 27

17

I HEREBY CERTIFY, That I attended deceased from March 12 1927 to March 15 1927

that I last saw him alive on March 15 1927

and that death occurred, on the date stated above, at 6:00 a.m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

Prematurity

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Maternal Syphilis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Wassermann.

(Signed) Margaret B. Tralle M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Leuser-Hzp

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Spec.—12 9 25—A Co.—200 Bks.

20186

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 20186

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS [redacted] 70-28 REGISTERED NO.

City of BALTIMORE: (No. _____ St., _____ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emanuel Fleck

(a) RESIDENCE NO. 2025 Wilhelm St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 17 1867

7 AGE: Years 60 Months _____ Days 27 28 IF LESS than 1 day ....hrs. or....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labour

(b) General nature of industry, business, or establishment in which employed (or employer) m. hair Factory

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Germany

10 NAME OF FATHER Henry Fleck

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Germany

PARENTS

14 Informant _____

(Address) Records

15 Filed [illegible] 1927 Per _____ Registrar

C. HAMPSON JONES, M. D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14 1927

17 I HEREBY CERTIFY, That I attended deceased from February 28 1926, to March 14, 1927, that I last saw h[illegible] alive on March 14, 1927, and that death occurred, on the date stated above, at 3.45 p m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) _____ yrs. _____ mos. 5 da.

CONTRIBUTORY (Secondary) _____

(duration) _____ yrs. _____ mos. _____ da.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? no Date of _____

Was there an autopsy? yes

What test confirmed diagnosis? laboratory

(Signed) R Hooper Lovell, M. D.

March 1927 (Address) [illegible]MORE CITY HOSPITALS

*State the Disease causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery Date of Burial Mar 16 1927

20 UNDERTAKER: George L. Schwab ADDRESS 1201 Fulton Ave.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20187

1-PLACE OF DEATH

## CERTIFICATE OF DEATH

181-007

E 20187

Registered No. C

City of BALTIMORE: (No. Franklin Sq. Hospital St., 19-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Magdalene Julie

(Residence in Baltimore: No. 1630 W Baltimore St St.; yrs.. mos.. ds.)

### PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Married

6-DATE OF BIRTH: July (Month) 15th (Day) 1907 (Year)

7-AGE: 19 yrs. 7 mos. 25 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or Country): Baltimore Md

10-NAME OF FATHER: Geoge Ohlverster

11-BIRTHPLACE OF FATHER (State or Country): Baltimore Md

12-MAIDEN NAME OF MOTHER: Anna Andrews

13-BIRTHPLACE OF MOTHER (State or Country): Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Anna Eilman.

(Address) 1038 Light St

Filed MAR 16 1927, 192

HARRISON JONES, M. D.

Registrar.

### CORONER'S CERTIFICATE OF DEATH

16-DATE OF DEATH: March (Month) 13th (Day) 1927 (Year)

17. I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Monoxide Gas Poisoning

(Duration) — yrs. — mos. 4 ds.

(CONTRIBUTORY, secondary) Inhaling Smoke from burning Clothes —

(Duration) — yrs. — mos. — ds.

(Signed) Thos. B. Horton M. D

(Coroner)

March 15th 1927 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death. yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

| 19-PLACE OF BURIAL OR REMOVAL. | DATE OF BURIAL. |
|---|---|
| Cedar Hill. | 3-16th 1927 |

| 20-UNDERTAKER. | ADDRESS |
|---|---|
| C & B Harle | 115 E West St |

Spec.—8-24-14—M. & T.—2000 Blks.

20188 HEALTH DEPARTMENT—CITY OF BALTIMORE E 20188

151

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE: (No. 24 W Church · ST. 22 31 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Richardson

(Residence in Baltimore: No. 24 W. Church st. St.; yrs., mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colord

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, unknown unknown, 1873.
(Month) (Day) (Year)

7-AGE, 53 54 yrs. unknown mos. ds.

If LESS than 1 day, ....hrs. or.....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Maryland.

10-NAME OF FATHER, unknown.

11-BIRTHPLACE OF FATHER (State or Country). unknown.

12-MAIDEN NAME OF MOTHER unknown.

13-BIRTHPLACE OF MOTHER (State or Country). unknown.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Richardson

(Address) 24 W. Church St.

Filed APR 6 1927 C. HAMPSON JONES, M. D. Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 15, 1927.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb. 14. 27. ~~1927~~ to Mch. 14. 27. ~~1927~~, that I saw h[er] alive on Mch. 14. 27. ~~1927~~, and that death occurred, on the date stated above, at 7. a. m.

The CAUSE OF DEATH* was as follows:

General Debility

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. 1 mos. ds.

(Signed) J. P. Strong M. D.

3-15-27, 191.. (Address) 506 N. Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Jon — DATE OF BURIAL, March 17. 1927

20-UNDERTAKER R. L. Parham — ADDRESS 1216 S. Sharp

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20189

## CERTIFICATE OF DEATH.

101-001

E 20189

REGISTERED NO.

(If death occurred in a bospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2422 Francis ST. 13-54 (WARD)

2-FULL NAME Mrs. Mary Bathell

(a) RESIDENCE NO. 2422 Francis ST., WARD ...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 ~~Life~~ mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of George Bathell

7 DATE OF BIRTH (month, day, and year) — — 1866

| 8 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ... min. |
|---|---|---|---|---|
| | 61 | — | — | |

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

10 BIRTHPLACE (city or town) (State or country) Frd. County Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Jesse Bathell

(Address) 2422 Francis

15 Filed MAR 16 1927 HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 13th 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar. 1 1927 to Mar. 13th 1927

that I last saw h alive on Mar. 13th 1927

and that death occurred, on the date stated above, at 3 20 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Terminal) 3 ds.

(duration) ... yrs. ... mos

CONTRIBUTORY (Secondary) Senility

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Jas. E. Ball M. D.

, 19 (Address) 713 Druid

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL 3/16 1927

20 UNDERTAKER Samuel P. Hensley — ADDRESS 578 W Baltimore

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20190

E 20190

## CERTIFICATE OF DEATH.

12-21 18003

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hosp. St. _____ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clarence Yancey

(a) RESIDENCE NO. 1527 Leslie St. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 15, 1915.

7 AGE: Years 11 Months 4 Days 26. IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Student

(b) General nature of industry, business, or establishment in which employed (or employer): do.

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) South Carolina

PARENTS

10 NAME OF FATHER Benj. Yancey

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Md.

12 MAIDEN NAME OF MOTHER Gertrude Jackson

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) S. C.

14 Informant Gertrude Yancey

(Address) 1527 Leslie St.

15 Filed May 16 1927 C. HAMPSON JONES, M. D. Registrar Per RRC

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) March 11, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inq (Inquest, autopsy or inquiry.) jury find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull (accidental)

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) automobile accident.

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Kennaway M. D.

(Coroner)

May 17 1927 (Address) 2702 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ..... mos., ..... ds. In the State ..... yrs., ..... mos., ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary Cem. Date of Burial: May 18 1927

20 UNDERTAKER: Mrs. P. A. Elliott ADDRESS: Woodland

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20191

101-001

## CERTIFICATE OF DEATH.

E 20191

1-PLACE OF DEATH

City of BALTIMORE: (No. Providence Hospital St., 5-9 Ward)

2-FULL NAME James Walker

(a) RESIDENCE NO. 623 N. Spring St. St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | colored | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lucy Walker.

6 DATE OF BIRTH (month, day, and year) about 1882

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 45 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer) General

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Md.

PARENTS

10 NAME OF FATHER _____

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Unknown

12 MAIDEN NAME OF MOTHER _____

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country)

14 Informant Mrs. Walker

(Address) Mt. Olivet, a.a.co. Md.

15 Filed MAR 16 1927 C. HARTON JONES, M. D. Registrar

Per _____

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) _____ yrs. _____ mos. 3 ds.

CONTRIBUTORY (Secondary) acute Nephritis

(duration) _____ yrs. _____ mos. _____ ds.

(Signed) C. T. Hemmeter, M. D.

(Coroner)

, 192 7 (Address) 7812 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death _____ yrs., _____ mos., _____ ds. In the State _____ yrs., _____ mos., _____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Magothy a.a.co Md. Date of Burial 3/16 1927

20 UNDERTAKER Byron Wright ADDRESS 1218 McElderry St

c.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20192

## CERTIFICATE OF DEATH.

E 20192

1-PLACE OF DEATH Boring Dw. No. 13

ITY OF BALTIMORE: (No.) 3018 Boring ST., (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John F Single

(a) RESIDENCE NO. 3018 Boring ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | Married |

If married, widowed, or divorced HUSBAND of (or) WIFE of Emily Single

DATE OF BIRTH (month, day, and year) Aug 26 1869

| AGE Years | Months | Days | If LESS than 1 day, .... hrs or .... min. |
|---|---|---|---|
| 57 68 | 2 6 | 4 16 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balt

10 NAME OF FATHER John Single

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Helen Krug

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Mitchell Single

(Address) 512 N Stricker

Filed MAR 16 1927 C. HAMPTON JONES M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14 1927

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1926 to Mar 14, 1927.

that I last saw him alive on Mar 13, 1927

and that death occurred, on the date stated above, at 945 A m.

The CAUSE OF DEATH* was as follows:

Chr Endocarditis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter W White-b, M. D.

3/15, 1927 (Address) 2800 N Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Holy Redeemer | March 1927 |

20 UNDERTAKER Kendall Jefferson ADDRESS 37 Inn Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

E 20193

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 20193

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 625 Carrollton Ave. St., 46-26 Ward) 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clayton Thomas

(a) Residence No. 625 Carrollton Ave St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

6-If married, widowed, or divorced HUSBAND of (or) WIFE of

7-DATE OF BIRTH (month, day and year) Unknown

8-AGE, 24 yrs. 3 mos. ..... ds. If LESS than 1 day, ....hrs. or....min.?

9-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer 040

(b) General nature of Industry, business, or establishment in which employed (or employer) Waiter

(c) Name of employer .....

10-BIRTHPLACE (city or town) (State or Country), 2

10-NAME OF FATHER, C. Thomas

11-BIRTHPLACE OF FATHER (city or town) (State or Country),

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER (city or town) (State or Country),

(Informant) Estelle Thomas

(Address) 625 Carrollton Ave

Filed APR 16 1927 HARTON JONES, M. D. Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 12-27

17- I HEREBY CERTIFY, That I attended deceased from Jan 2, 1927 to March 12 1927

that I last saw h— alive on March 11, 1927

and that death occurred, on the date stated above, at 8.45 A.M.

The CAUSE OF DEATH* was as follows:

Bronchiectasis

Complicating Pulmonary Tuberculosis

(Duration) yrs. 2 mos. 13 ds.

CONTRIBUTORY (Secondary) Bronchiectasis

(Duration) yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? I do not know

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) Abram C. Stewart M. D.

, 19 (Address) 704 N. Fayette Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt Auburn — DATE OF BURIAL, Mar 16 1927

20-UNDERTAKER, Stayman & Brooks — ADDRESS, 423 Fayette

Spec.—6-9-19—H. P. Co.—1000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20194

CERTIFICATE OF DEATH.

15-59 101-001

E 20194

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: No 1617 N. Carey ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Dennis Ford.

(a) RESIDENCE. No 1617 N. Carey ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ✓ mos. ✓ ds. How long in U. S., if of foreign birth? ✓ yrs. ✓ mos. ✓ ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: ~~White~~ Colored.

5 Single, Married, Widowed, or Divorced (write the word): Married

6 If married, widowed, or divorced: HUSBAND of ~~(or WIFE of)~~ Laura F. Ford.

7 DATE OF BIRTH (month, day, and year) Unknown

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 67 | ✓ | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Janitor Forest Court Apt.

(b) General nature of industry, business, or establishment in which employed (or employer): Looking after Apartments

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Calvert Co Md.

10 NAME OF FATHER Edward Ford.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Calvert Co. Md

12 MAIDEN NAME OF MOTHER Lucinda Gross.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Calvert County Md

14 Informant (Address): Laura Ford 1617 N. Carey

15 Filed MAR 16 1927 19 Registrar C. HAMILTON JONES, M. D.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 1927

17 I HEREBY CERTIFY, That I attended deceased from Febry 19 27, to March 12 19 27, that I last saw h[er] alive on March 12 19 27, and that death occurred, on the date stated above, at 10.20 p. m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Lobar)

(duration) ✓ yrs. ✓ mos. 7 ds.

CONTRIBUTORY (Secondary) Pericarditis

(duration) ✓ yrs. 1 mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of /

Was there an autopsy? No

What test confirmed diagnosis? Clinical methods

(Signed) George L. Shannon, M. D.

3/12, 1927 (Address) 700 Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet DATE OF BURIAL: Mar 16 27

20 UNDERTAKER: Wagner & Brook ADDRESS: 1463 W. Lex

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20195

## CERTIFICATE OF DEATH.

90 E 20195

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1718 Chilton St., 9-46 Ward)

2-FULL NAME Anthony J. Schmitt

(a) RESIDENCE NO. 1718 Chilton St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 3 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Widower

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov. 1 1860

7 AGE: Years 66 | Months 3 | Days 14 | If LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto. (State or country): Md.

10 NAME OF FATHER: John Schmitt

11 BIRTHPLACE OF FATHER (city or town): (State or country): Balto.

12 MAIDEN NAME OF MOTHER: Meinezer

13 BIRTHPLACE OF MOTHER (city or town): Balto. (State or country):

14 Informant: Mrs. Anthony Schmitt (Address) 1718 Chilton St

15 Filed ... 19 ... Registrar

16 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 14 19 27

17 I HEREBY CERTIFY, That I attended deceased from Nov 4 27, to Mar 14 27, 19..., that I last saw h... alive on Mar 14 27, 19..., and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Hem. Diathesis

Heart.

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary): Myocarditis, Heart

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) ..., M. D.

..., 19 ... (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — Date of Burial: March 17 19 27

20 UNDERTAKER: Jos. J. Herr — ADDRESS: 156 N. Luzerne

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 20196

20196

## CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 8-17 Ward)

2-FULL NAME Mary Jane Ellis

(a) RESIDENCE NO. 1619 Walker St St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | col | single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) Feb 22/26

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 1 | 0 | 19 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md

10 NAME OF FATHER Geo. Abbert Ellis

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto., Md

12 MAIDEN NAME OF MOTHER Mary Tilghman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Phila. & Pa.

14 Informant Mary Ellis

(Address) 1619 Walker St

15 Filed 1927 C. HARRISON JONES, M. D.

Per _____ Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 13/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Autopsy at Hospital)

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) J. Lee Rountree M. D.

(Coroner)

3/16/27 (Address) 503 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death .....yrs., .....mos., .....ds. In the State .....yrs., .....mos., .....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Cem. Date of Burial March 17 1927

20 UNDERTAKER Wm J. G. Locke ADDRESS 1302 Jefferson

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 20197

REGISTERED E 20197

27-48

1-PLACE OF DEATH

City of BALTIMORE: (No. 713 Sterling St. 7 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Howard Wheeler

(a) RESIDENCE NO. 6002 Pressman Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | col | single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXX

6 DATE OF BIRTH (month, day, and year) Feb 21/1906

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 21 | 0 | 19 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Albert Wheeler

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Frances Howard

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Penna.

14 Informant Frances Wheeler

(Address) 6002 Pressman Ave

15 Filed 1927 C. HAMPSON JONES, M. D.

Per Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 12/27 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or Inquiry.) Inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocarditis (History of Rheumatism)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Alcoholism

(duration) yrs. mos. ds.

(Signed) M. D.

(Coroner)

3/10/27 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dr. Peters Cem. Date of Burial: Mch 17 1927

20 UNDERTAKER: Mrs J. G. Locke ADDRESS: 1302 Jeffers

ec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

20198

## CERTIFICATE OF DEATH

90 E 20198

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No. 2325 N. Calvert ST. 17-50 WARD)

2-FULL NAME Margaret A Krok

(a) RESIDENCE NO. 2325 N. Calvert ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. 0 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of: S. L. S. Krok

DATE OF BIRTH (month, day, and year): Feb. 25 1854

AGE: Years 72 Months 0 Days 17 If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Baltimore Md.

10 NAME OF FATHER: John H. Wagner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Margaret Beale

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

Informant: Mr Howard S Krok

(Address): 508 Woodlawn Rd

C. HARRY [illegible], M. D.

Filed: JUL 16 1927

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 14 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan 10, 1927, to Mar 14, 1927, that I last saw h[illegible] alive on Mar 14, 1927, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows: Chronic Myocarditis

(duration) 3 yrs mos ds.

CONTRIBUTORY (Secondary) [illegible]

(duration) yrs mos ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? [illegible]

(Signed) [illegible] M. D.

3/15 1927 (Address) 2724 N Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery — DATE OF BURIAL: Mar 16 1927

20 UNDERTAKER: Wm Mickley Sons — ADDRESS: North Pa

rc.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20199

## CERTIFICATE OF DEATH

74-001

E 20199

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

ITY OF BALTIMORE: (No.) 3306½ North Ave. (WARD) 15-67

2-FULL NAME George A Snodeal

(a) RESIDENCE NO. 3306½ North Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

If married, widowed, or divorced HUSBAND of (or) WIFE of Lily Snodeal

DATE OF BIRTH (month, day, and year) Oct 22 1856

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 70 | 11 | 14 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) West Virginia

10 NAME OF FATHER John Snodeal

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ? Grant

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

Informant Mrs. Lily Snodeal

(Address) 3306 N. North Ave

Filed 1927 C. HAMILTON JONES, M. D.

Per ____ Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1st 1927 to March 14 1927

that I last saw he alive on March 14 1927

and that death occurred, on the date stated above, at 8 P M

The CAUSE OF DEATH was as follows:

Cerebral Hemorrhage

(duration) yrs. 3 mos 4 ds.

CONTRIBUTORY (Secondary) Rheumatic Arthritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~~~

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Albert F Montemuro, M. D.

(Address) 6388 Falls Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Loudon Park Cem | March 16 1927 |
| 20 UNDERTAKER Wm J Tucker & Son | ADDRESS Balto |

Spec.—7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

107-001

E 20200

E-20200

## CERTIFICATE OF DEATH

1-PLACE OF DEATH University Hospital

REGISTERED NO.

City of BALTIMORE: (No. ____ St., 9-46 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Esther M Smith

(a) RESIDENCE NO. 1903 E 28th St St. ____ Ward ____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 30 years mos. ____ ds. ____ (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. ____ mos. ____ ds. ____

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert L Smith

6 DATE OF BIRTH (month, day, and year) Oct 9 - 1895

7 AGE — Years: 31 Months: 5 Days: 5 IF LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ____ (State or country) Maryland

PARENTS

10 NAME OF FATHER Walter Jenkins

11 BIRTHPLACE OF FATHER (City or town) ____ (State or country) ? Maryland

12 MAIDEN NAME OF MOTHER Mollie Bean

13 BIRTHPLACE OF MOTHER (city or town) ____ (State or country) Maryland

14 Informant Robt L Smith (Address) 1903 E 28th St

15 Filed MAY 16 1927 C. HAMILTON JONES, M. D. Registrar Per RH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/14/27

17 I HEREBY CERTIFY, That I attended deceased from 3/12/27, 19____, to 3/14/27, 19____, that I last saw her alive on 3/14/27, 19____, and that death occurred, on the data stated above, at 10-45 p.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ____ yrs. ____ mos. 4 ds.

CONTRIBUTORY (Secondary) Asthenia

(duration) ____ yrs. 8 mos. ____ ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) J S Winstead, M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge — Date of Burial: May 18 27

20 UNDERTAKER: H S Marshall — ADDRESS: 3539 Gallows

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20201

101-001

E 20201

## CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 429 N. Calhoun St., 6-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John L. Gross

(a) RESIDENCE NO. 429 N. Calhoun St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rebecca Gross

6 DATE OF BIRTH (month, day, and year): 1882

7 AGE: Years 45 Months Days IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Real Estate

(b) General nature of industry, business, or establishment in which employed (or employer): Dealer 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Calvert Co. Md.

PARENTS

10 NAME OF FATHER: John Gross

11 BIRTHPLACE OF FATHER (City or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Rebecca Gross 429 N. Calhoun St.

Filed APR 16 1927 HARRY H. JONES, M. D. Registrar

Per R.H.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927: March 13

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1927, to March 13, 1927, that I last saw him alive on March 12, 1927, and that death occurred, on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows: Pneumonia Lobar

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. 13 ds.

18 Where was disease contracted: Home

If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Observation & Symptoms

(Signed) C. T. Fisher M. D.

March 18 1927 (Address) 712 S. Bond St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem. Date of Burial 3/16 1927

20 UNDERTAKER: Samuel Kennedy ADDRESS W. Balto

Spec. -7-17-26—A Co.—200 Bks.

20202

# HEALTH DEPARTMENT—CITY OF BALTIMORE

74 801 E 20202

## CERTIFICATE OF DEATH

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No.) 6 Paca St. (Ward) 25-22

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George F. Monroe

(a) RESIDENCE NO. 6 Paca St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male / Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of Mary Monroe

6 DATE OF BIRTH (month, day, and year): 1832

7 AGE — Years: 95 — Months — Days — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(r) Name of employer

9 BIRTHPLACE (city or town) Gloucester Co. Va

(State or country)

PARENTS

10 NAME OF FATHER James Monroe

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown

(State or country)

14 Informant Mary Monroe

(Address) 6 Paca St

15 Filed ..... 19 ..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-14-1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1927, to 3-14-, 1927,

that I last saw h[illegible] alive on 3-14-, 1927,

and that death occurred, on the date stated above, at 2.30 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Alphonso Dixon M. D.

. 19 (Address) 117 North 12th

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — Date of Burial: 3/16/27

20 UNDERTAKER: Samuel Hensley — ADDRESS: [illegible]

MAR 16 1927 C. REGISTRAR

Spec.—12-9-25—A Co.—200 Bks.

E 20203

# HEALTH DEPARTMENT—CITY OF BALTIMORE

111-001

E 20203

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS [redacted] 17-24 REGISTERED NO.

City of BALTIMORE: (No. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Bell

(a) RESIDENCE NO. 949 Penn St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Negro | Widowed |

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1870

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 51 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town)

(State or country) North Carolina

10 NAME OF FATHER John Gregory

11 BIRTHPLACE OF FATHER (city or town)

(State or country) N. C.

12 MAIDEN NAME OF MOTHER Hanna Commanda

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) North Carolina

PARENTS

14 Informant (Address) Friends

15 Filed ..... 19 C. HARRISON JONES, M.D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 1927

17

I HEREBY CERTIFY, That I attended deceased from February 10, 1927, to March 12, 1927, that I last saw h[illegible] alive on March 11, 1927, and that death occurred, on the date stated above, at 5A m.

The CAUSE OF DEATH* was as follows:

Lesnlity
Perforated Gastric Ulcer
Generalized Peritonitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Laboratory

(Signed) R Hooper Pleasants M.D.

March 13 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery Date of Burial 3/16, 1927

UNDERTAKER Jno Geo A Hooper & Conway ADDRESS 406

MAR 18 1927

Spec.–7-17-26—A Co.—200 Bks.

E 20204

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

X 118-002

E 20204

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Univ. Hosp. St. 430 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Grund

(a) RESIDENCE NO. 6 Admiral Blvd St. Dundalk Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | child |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 10 1927

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min.. |
|---|---|---|---|---|
| | | | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Dundalk Md

(State or country)

PARENTS

10 NAME OF FATHER Geo. W Grund

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Balto

12 MAIDEN NAME OF MOTHER Leona Holstein

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Cumberland Md

14 Informant University Hospital

(Address)

15 Filed 1927 18 C. HARRISON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 16 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 15, 1927, to March 16, 1927, that I last saw him alive on March 16, 1927, and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction due to congenital atresia of ileum and portion of duodenum

(duration) yrs. mos. 6 ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of 3/16/27

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) E. E. Lusby, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Oak Lawn Cemetery | 3/19 1927 |
| 20 UNDERTAKER H. Sauder & Son. | ADDRESS 170 Flut St |

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

20205

## CERTIFICATE OF DEATH.

31 E 20205

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. 26-11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Koch

(a) RESIDENCE NO. 3317 Philadelphia Road St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1874

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 53 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

10 NAME OF FATHER Joseph Ziegler

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Cornelia Gevaghy

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

PARENTS

14 Informant Hospital Records

(Address)

Filed APR 16 1927 HARRY M. JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from March 4, 19 27, to March 15, 19 27, that I last saw her alive on March 15, 19 27, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fistula in ano Umbilical hernia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) W. E. Gatins, M. D.

3-15-27 19 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Date of Burial March 17 1927

20 UNDERTAKER A. Kraus Evans ADDRESS 38 E Fort Ave

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

100-001 E 20206

E 20206

24-35

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1611 Belt St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Russell E. Cage.

(a) RESIDENCE NO. 1611 Belt St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 6 mos. 0 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. da.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male. | White. | Infant. |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept, 9, 1926.

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min.. |
|---|---|---|---|---|
| | | 6, | 6. | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Harry C. Cage.

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Louise Dawson.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va.

14 Informant Harry C. Cage, (Father).

(Address) 1611 Belt St.

15 Filed [illegible] 1927 [illegible] Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 1, 1927, to Mar 15, 1927,

that I last saw h[illegible] alive on Mar 15, 1927,

and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

Primary

(duration) yrs. mos. 16 da.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 da.

18 Where was disease contracted —

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. E. H. Campbell, M. D.

Mar 16, 1927 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Cedar Hill Cem | March 17, 1927 |
| **20 UNDERTAKER** | **ADDRESS** |
| A. Howard Evans | 386 Ford Ave |

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20207

CERTIFICATE OF DEATH.

100-001

E 20207

1-PLACE OF DEATH

City of BALTIMORE: (No. 2414 Callow ave 13-59 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sheba Wennkrantz

(a) RESIDENCE NO. 2414 Callow Ave Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Bernard

6 DATE OF BIRTH (month, day, and year): Unk

7 AGE: Years 80 | Months — | Days — | IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Russia

(State or country)

PARENTS

10 NAME OF FATHER: Samuel Rosenthal

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Russia

12 MAIDEN NAME OF MOTHER: Bella —

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Russia

14 Informant: Mrs H. Rosenberg

(Address): 2414 Callow Ave

MAR 16 1927 Filed

HAMILTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-15 1927

17 I HEREBY CERTIFY, That I attended deceased from 3-1, 1927, to 3-15, 1927

that I last saw h.e.r alive on 3-15 1927

and that death occurred, on the date stated above, at 10 p m.

The CAUSE OF DEATH* was as follows:

Cerebral Arteriosclerosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Terminal Bronchopneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) [illegible], M. D.

3/15 1927 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Washington Rd

Date of Burial: 3/17 1927

20 UNDERTAKER: Sol Levinson & Bro

ADDRESS 1127 E Baltimore st

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 20208 45 E 20208

28-6

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 5308 Wayne Avenue St. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha VandenBerg Hoffman

(a) RESIDENCE NO. 5308 Wayne Avenue St. Ward Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. ? mos. ? ds. How long in U. S. if of foreign birth? 45 yrs. ? mos. ? ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eugene E. Hoffman

6 DATE OF BIRTH (month, day, and year) November-8-1861

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min.. |
|---|---|---|---|---|
| | 65 | 4 | 7 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Amsterdam

(State or country) Holland

PARENTS

10 NAME OF FATHER O. O. VandenBerg

11 BIRTHPLACE OF FATHER (City or town) Amsterdam

(State or country) Holland

12 MAIDEN NAME OF MOTHER Harmine Blinkman

13 BIRTHPLACE OF MOTHER (city or town) Amsterdam

(State or country) Holland

14 Informant Miss. Henrietta VandenBerg (sister)

(Address) 1433 Park Avenue.

15 Filed 1927 C. HAMILTON JONES, M. D. Registrar

Per R.L.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 March 15 - 1927 -

17 I HEREBY CERTIFY, That I attended deceased from December, 1926, to March 14, 1926, that I last saw h Er alive on March 14 Th, 1926, and that death occurred, on the date stated above, at 5 A. M.

The CAUSE OF DEATH* was as follows:

Carcinoma Hepatic Flexure Colon

(duration) 3 yrs. - mos. - ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction.

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of Jan 27.

Was there an autopsy? No -

What test confirmed diagnosis? Microscopic section -

(Signed) Hugh Brent -, M. D.

. 19 (Address) 16 E. Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Presbyterian Cem. Govans. Date of Burial Mar-17-27 19

20 UNDERTAKER J. THOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

Spec.—12-9-25—A Co.—200 Bks.

Icenrod.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

11-001

## CERTIFICATE OF DEATH.

E 20209 PLACE OF DEATH Sinai Hospital 6-9 REGISTERED NO. E 20209

City of BALTIMORE: (No. ____ St. ____ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Icenrod.

(a) RESIDENCE NO. 526 N. Castle St. St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred / yrs. 1 mos. ds. How long in U. S., if of foreign birth? / yrs. 1 mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 Color or Race: White | 5 Single, ~~Married, Widowed,~~ or ~~Divorced,~~ (write the word): Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ____

6 DATE OF BIRTH (month, day, and year) Feb 15/1926

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 1 | 0 1 | 29 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ____ ad

(b) General nature of industry, business, or establishment in which employed (or employer) ____

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER William Icenrod

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md

(State or country)

12 MAIDEN NAME OF MOTHER Sadie Little

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md.

(State or country)

14 Informant Mrs. Sadie Icenrod

(Address) 5269 Castle St

15 Filed ____ 19 C. HAMPSON JONES, M. D. Registrar

1 6 1927 Per ____

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 11, 1927, to Mar 14, 1927, that I last saw him alive on Mar 14, 1927, and that death occurred, on the date stated above, at 10-45 P. m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) ____ yrs. ____ mos. 7 ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) ____ yrs. ____ mos. 5 ds.

18 Where was disease contracted if not at place of death? ____

Did an operation precede death? No Date of ____

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John B. Lassen, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — Date of Burial: Mar 17 1927.

20 UNDERTAKER: Wm. C. Miller & Son — ADDRESS: 2334 Jefferson

Spec.—12-9-25—A Co.—200 Bks.

E 20210

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-E 20210

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [illegible] St. 3-4 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eleanor Chester

(a) RESIDENCE NO. 736 S. Dallas St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Negro

5 Single, Married, Widowed, or Divorced, (write the word): ?

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1862

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 65 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Maryland

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town):

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) ?

14 Informant (Address) BALTIMORE CITY HOSPITALS

Filed MAR 16 1927 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14 1927

17 I HEREBY CERTIFY, That I attended deceased from September 24, 1926, to March 14, 1927, that I last saw h[illegible] alive on March 14, 1927, and that death occurred, on the date stated above, at 1:15 P.m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Gen'l & Laboratory

(Signed) R Hooper Lamb M. D.

March 15 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND Date of Burial MAR 16 1927

20 UNDERTAKER C. HARRISON JONES, M. D. ADDRESS

Commissioner Health

Spec.—12-9-25—A Co.—200 Bks.

E 20211

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20211

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St. 16-37 Ward) 100-180

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nathan Marshall

(a) RESIDENCE NO. ? St. Ward

(Usual place of abode) [redacted]

Length of residence in city or town where death occurred ? yrs. mos. ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Negro

5 Single, Married, Widowed, or Divorced. (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1857

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 70 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Maryland

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town):

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) ?

14 Informant

(Address) Records

MAR 1927 C. HARRISON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14 1927

17 I HEREBY CERTIFY, That I attended deceased from November 28 1926, to March 14, 1927, that I last saw h.. alive on March 13, 1927, and that death occurred, on the date stated above, at 6:20 A m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? gemral & Laboratory

(Signed) R Hooper Smith, M. D.

Mch 15 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

19

20 UNDERTAKER ADDRESS

UNIVERSITY OF MARYLAND MAR 19 1927

...c.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20212

E 20212

## CERTIFICATE OF DEATH.

11-24 | 161-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 918 E. Madison ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Owens Buck

(a) RESIDENCE NO. 918 E. Madison ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | C | S |

If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

DATE OF BIRTH (month, day, and year) 3-14-27

| AGE | Years | Months | Days | If LESS than 1 day, 1 hrs. or 1 min. |
|---|---|---|---|---|
| | | | | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore, Md.

10 NAME OF FATHER Samuel Owens

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Viola Buck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

Informant mother

(Address)

FILED 1927 C. HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-14 1927

17

I HEREBY CERTIFY, That I attended deceased from 3-14, 1927, to 3-14, 1927,

that I last saw h— alive on 3-14, 1927,

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) malnutrition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. L. Berry, M. D.

, 19 (Address) 1520 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — JOHNS HOPKINS HOSPITAL

DATE OF BURIAL — 19

20 UNDERTAKER

ADDRESS

Commissioner of Health.

MAR 16 1927

For Wm. S. WOODALL

Cor.—12-9-26—A Co.—200 Bks.

A L Hankins

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20213

CERTIFICATE OF DEATH.

89 E 20213

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 406 W Balt St. 325 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME A L. Hankins

(a) RESIDENCE NO. 406 W Balt St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): not given

7 AGE: Years: about 50 Months: Days: IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Mfr

(b) General nature of industry, business, or establishment in which employed (or employer): Mfr

(c) Name of employer: Self

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

PARENTS

14 Informant

(Address)

15 1927 C. HAMPSON JONES, M. D.

Par AKM Registrar

167

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/25 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest find that said deceased came to h death (Inquest, autopsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) Samuel A Hankins M. D.
(Coroner)

, 19 27 (Address) 325 W Balt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence (City or Town) Same

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem Date of Burial 2-28-27. 19

20 UNDERTAKER ADDRESS

Geo. Weber 220 E Fayette

UNIVERSITY OF MARYLAND. MEDICAL SCHOOL. MORGUE. Gen. R. Dorsey Hall

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20214

CERTIFICATE OF DEATH.

101-101

E 20214

1-PLACE OF DEATH

City of BALTIMORE: (No. 2330 Penna Ave, St., 14-59 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm Brewer

(a) RESIDENCE NO. 2330 Penna Ave. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) About 1884

7 AGE: Years 43; Months; Days; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) (General)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) N. C.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant

(Address)

Filed 1927 C. HAMPSON JONES, M. D.

Per Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 19 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) and from Jury find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) No history

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.

(Coroner)

2/23, 1927 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial MAR 16 1927 19

20 UNDERTAKER ADDRESS

Commissioner Health

THE MORGUE.

Per Wm. E. Woods

UNIVERSITY OF MARYLAND

Spec.—12-9-25—A Co.—200 Pks.

201074

E 20215

1-PLACE OF DEATH

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

117 E 20215

REGISTERED NO.

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 3-5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Bowles

(a) RESIDENCE NO. 1113 Watson St. Balto-Inst. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): 1889

7 AGE — Years: 38 — Months: — Days: — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Worked in Store

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country): Md

10 NAME OF FATHER: Silas Bowles

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Va

12 MAIDEN NAME OF MOTHER: Mary —

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): — Va

PARENTS

14 Informant: Records

(Address): JOHNS HOPKINS HOSPITAL

15 1927 C. HAMPSON JONES, M. D. Registrar

Pay 1911

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: Mar 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 12, 1927, to Mar 14, 1927, that I last saw h[illegible] alive on Mar 14, 1927, and that death occurred, on the date stated above, at 2 0 m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis & perforation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): paralytic ileus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Mar 13

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Percy A. Johnson M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel cemetery Date of Burial Mar 17 27

20 UNDERTAKER: Edward Bryan ADDRESS 1681 orleans st

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

20216

## CERTIFICATE OF DEATH.

74 E 20216

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1876 N Chester ST. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine L. Glantz

(a) RESIDENCE NO. 1876 N Chester ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 5 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Miriam A. Glantz

DATE OF BIRTH (month, day, and year) Sept 1-1876

| AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 50 | 6 5 | 14 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER L. Henry Hammert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Amelia Rodd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Miriam A. Glantz

(Address) 1876 N Chester St

1927 C. HAMPSON JONES, M. D. Registrar

6 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug, 1925 to March 15, 1927.

that I last saw h[illegible] alive on March 15, 1927,

and that death occurred, on the date stated above, at 11½ a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Cardio-Vascular Disease.

(duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Stanislaus Malelong, M. D.

, 19 (Address) 1609 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem.

DATE OF BURIAL March 18 1927

20 UNDERTAKER John Ullrich

ADDRESS 2 E Eden

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20217 E 20217

## CERTIFICATE OF DEATH

1-PLACE OF DEATH Nursery & Children's Hospital

CITY OF BALTIMORE: (No. Franklin and Schroeder Sts.) (10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Ernest Keegan

(a) RESIDENCE NO. Franklin and Schroeder ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) March 14, 1924

| AGE Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|
| 3 | | 2 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore, Md.

10 NAME OF FATHER Ernest Edward Keegan

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Elsie Carver

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Charlottesville, Va.

Informant Mrs. Mary Horsfall Watson Schroeder & Walbert

Filed 1927 O. HAMPSON JONES, M. D., Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16, 1927

17 I HEREBY CERTIFY, That I attended deceased from March 11, 1927, to March 16, 1927, that I last saw him alive on March 15, 1927, and that death occurred, on the date stated above, at 7.05 A m.

The CAUSE OF DEATH* was as follows:

Influenzal Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Partial

What test confirmed diagnosis?

(Signed) Fredrick Bidart, M. D.

, 19 (Address) 920 St Paul.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Mar 17 1927

20 UNDERTAKER George J. Smith — ADDRESS 1532 Hollins

Spec.—12-9-25—A Co.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20218 — 118-002 — E 20218

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Mercy Hospital

City of BALTIMORE: (No. 13-59 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Solomon Fedrman

(a) RESIDENCE NO. 7107 Lakewood Ave St. Ward W. Virginia

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) About 1875

7 AGE: Years 52 | Months — | Days — | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer): 066

(c) Name of employer

9 BIRTHPLACE (city or town): Unknown

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant: Hospital Records

(Address) Mercy Hosp.

17 C. HAMILTON JONES, M. D. Registrar

1927 Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16 1927

17 I HEREBY CERTIFY, That I attended deceased from March 3, 1927, to March 16, 1927, that I last saw h.. alive on March 16, 1927, and that death occurred, on the date stated above, at 3:20 p. m.

The CAUSE OF DEATH* was as follows:

Prostatic Hypertrophy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Paralytic Ileus

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of 3/10/27

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. Mella, M. D.

3/16, 1927 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Pk. Crematory Date of Burial 3/18/1927

20 UNDERTAKER: Edward Sondheim ADDRESS 1823 W. Mt. Royal Ave

Spec. -7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 20219

101-09

E 20219

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 2562 Frederick Ave. St. 20-69 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Virginia Yookel

(a) RESIDENCE NO 2562 Frederick Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick Yookel

6 DATE OF BIRTH (month, day, and year) October 15, 1869

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|---|
| | 57 | 5 | 0 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Alfred E. Lewis

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Norfolk, Va.

12 MAIDEN NAME OF MOTHER Sarah Ware

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant Robert E. Lewis

(Address) 323 S. Garrison Lane

3-15 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 March 15, 1927

17 I HEREBY CERTIFY, That I attended deceased from March 11, 1927, to March 15, 1927, that I last saw her alive on March 14, 1927, and that death occurred, on the date stated above, at 3.30 a. m.

The CAUSE OF DEATH* was as follows:

Double Lobar Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry D McCarty, M. D.

(Address) 37 West preston Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Loudon Park Cemetery | Mar. 17 1927 |

20 UNDERTAKER Leupold & Cook

ADDRESS 1003 W. Pratt

cc.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

20220

E 20220

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH West Baltimore General Hospital REGISTERED NO. 29

CITY OF BALTIMORE: (No.) Rayner and Dukeland (St.) 18 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Addie E. Slacum

(a) RESIDENCE NO. 939 Hollins ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) May 2, 1914

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 12 | 10 | 14 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

10 NAME OF FATHER Wm. J. Slacum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dorchester Co., Md.

12 MAIDEN NAME OF MOTHER Ada E. Mathews

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dorchester Co., Md.

Informant Wm. J. Slacum

(Address) 939 Hollins St.

6 1927 C. HAMPSON JONES, M. D.

Per Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/16 1927

17

I HEREBY CERTIFY, That I attended deceased from 3/15, 1927, to 3/16, 1927

that I last saw her alive on 3/16, 1927

and that death occurred, on the date stated above, at 10 50 A m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Benjamin Miller, M. D.

, 19 (Address) W. B. G. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Mar. 18, 1927

20 UNDERTAKER: Joseph B. Cook

ADDRESS: 1003 N. Gilts St.

Cor.—1-12-23—M&T—100 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20221 E 20221

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

TY OF BALTIMORE (No.) 2609 Oak. ST. 17-51 WARD)

2-FULL NAME Sarah E. Meise

(a) RESIDENCE NO. 2609 Oak. ST., 12 WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 1 yrs. 4 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

X | 4 COLOR OR RACE | 5 ~~Single, Married,~~ Widowed, or ~~Divorced (write the word)~~

W. | Widow

married, widowed, or divorced
HUSBAND of
(or) WIFE of Henry Meise

TE OF BIRTH (month, day, and year) June 11 1856

| E | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| 71 | 70 | 9 | 3 | |

CUPATION OF DECESED
a) Trade, profession or articular kind of work 037
b) General nature of industry, usiness, or establishment in hich employed (or employer) Home - Work.
) Name of employer

THPLACE (city or town) York-Co-Pa
tate or country)

NAME OF FATHER Joseph W Wantland

BIRTHPLACE OF FATHER (city or town)
(State or country) York Co - Pa.

MAIDEN NAME OF MOTHER Mary J Fayler.

BIRTHPLACE OF MOTHER (city or town)
(State or country) York Co Pa.

nformant Wm O Butcher
Address) 2609 Oak St

1927 C. HAMPSON JONES, M. D.
Per Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/14 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) John H Morrison M. D.
(Coroner)

3/16, 192 7 (Address) 3632 Roland Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| New Freedom Cem (Pa) | Mar 17 1927. |
| 20 UNDERTAKER | ADDRESS |
| J. O. Mitchell ~~Not to.~~ 1900 Eutaw place | |

Spec.—7-17-26—A Co.—200 Bks.

Dr Metzel 1903 N Vath Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20222

CERTIFICATE OF DEATH

74-001

E 20222

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1822 N. Monroe St. 15-71 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Matthaei

(a) RESIDENCE NO. 1822 N Monroe St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| F | W | Widowed |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Jamil Matthaei

6 DATE OF BIRTH (month, day, and year) Apr 11, 1842

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 84 | 11 | 4 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Albert E Bromert

(Address) 40 N Main Ave

15 MAR 17 1927 C. HAMPSON JONES, M. D.

Per A.D.B. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 15 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1927 to Mar. 15, 1927.

that I last saw her alive on Mar. 15, 1927.

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 1 mos. 16 ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 16 ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) R. C. Metzel, M. D.

3/16. 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mortinsburg, W. Va. Date of Burial Mar 19 1927

20 UNDERTAKER W. M. Cook ADDRESS 502 E North Ave

Spec.–7-17-26–A Co.—200 Bks.

Dr. Morgenthoyd, 23th. & Barclay Sts.

HEALTH DEPARTMENT—CITY OF BALTIMORE

20223

11-00 V E 20223

## CERTIFICATE OF DEATH

REGISTERED NO. 24-35

1-PLACE OF DEATH

City of BALTIMORE: (No. ~~Elizabeth~~ 612 Aull St. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth E Bell

(a) RESIDENCE NO. 612 Aull, St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 11, 1846

7 AGE: Years 80 Months 6 Days 31 IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Maryland

PARENTS

10 NAME OF FATHER Geo. H. Watkins

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Jane Stills

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) England

14 Informant: Franklin C. Bell

(Address) 612 Aull St.

15 Filed C. HARRISON JONES, M. D. Registrar

1927 Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14 1927

17 I HEREBY CERTIFY, That I attended deceased from March 9 1927 to March 14 1927 that I last saw her alive on March 14 1927 and that death occurred, on the date stated above, at 1.10 P. m.

The CAUSE OF DEATH* was as follows:

La Grippe

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Geo. W. Thoyd M.D.

3/15 1927 (Address) 401 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Pk Cem — Date of Burial: Mar 17 1927

20 UNDERTAKER: H. McCook — ADDRESS: 5 or E Monument

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20224

## CERTIFICATE OF DEATH.

D-3345

E 20224

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospitals St. _____ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Bruske

(a) RESIDENCE NO. 333 E Hamburg St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1/0 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Augusta M Bruske

6 DATE OF BIRTH (month, day, and year): 1865

7 AGE: Years 61 (62) | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED:

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Ireland

(State or country)

10 NAME OF FATHER: Wm H Bruske

11 BIRTHPLACE OF FATHER (city or town): Ireland

(State or country)

12 MAIDEN NAME OF MOTHER: Katherine Dyer

13 BIRTHPLACE OF MOTHER (city or town): Ireland

(State or country)

14 Informant: Wm N. Bruske

(Address) 333 E. Hamburg St.

15 Filed 6 1927 C. HAMPSON JONES, M. D.

Per ORF Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 14 1927

17 I HEREBY CERTIFY, That I attended deceased from 2-11- 1926 to 3-14 1927

that I last saw him alive on 3-14 1927

and that death occurred, on the date stated above, at 12 midnight

The CAUSE OF DEATH* was as follows: Carcinoma of Splenic Flexure of Colon

Chronic Pancreatitis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Synovial Sarcoma

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of Oct. 6, 1926

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) W Blaycock M. D.

, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill — Date of Burial: Mar 15 1927

20 UNDERTAKER: Wm Cook — ADDRESS: 507 Elliott Ave

(Volden)

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20225

E 20225

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

BALTIMORE CITY HOSPITALS 6-9

City of BALTIMORE: (No. [redacted] St., Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Volden

(a) RESIDENCE NO. 240 N. Bond St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE: Years 77; Months; Days; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

10 NAME OF FATHER Andrew Craig

11 BIRTHPLACE OF FATHER (city or town)

(State or country) France

12 MAIDEN NAME OF MOTHER Maggie Gold

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) France

14 Informant (Address) City Hospitals Records

15 [redacted] 1927 C. HAMPSON JONES, M. D.

Per [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/15 1927

17 I HEREBY CERTIFY, That I attended deceased from July 11 1926 to March 15 1927 that I last saw her alive on March 15 1927 and that death occurred, on the date stated above, at 12.30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

arteriosclerosis

hypertension

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? general appearance

(Signed) C. Holmes Bonsel, M. D.

, 19 BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery Date of Burial: Mar 17 1927

20 UNDERTAKER: Hughes & Jones ADDRESS: 1st & 2nd N. Broadway

...ec.—6-9-19—H. P. Co.—1000 Bkn.

E 20226

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20226

## CERTIFICATE OF DEATH.

25-32 129

1-PLACE OF DEATH (a) CITY OF BALTIMORE: (No.) 14 Annapolis Road. ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Grant

(a) RESIDENCE. NO. 14 Annapolis Road ST., WARD.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Female | White | Widowed |

6 If married, widowed, or divorced HUSBAND of (or) WIFE of John F. Grant

DATE OF BIRTH (month, day, and year) [illegible] 1870

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| 57 | 56 | 10 | 22 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) md.

10 NAME OF FATHER William Arnold.

11 BIRTHPLACE OF FATHER (city or town) (State or country) md.

12 MAIDEN NAME OF MOTHER Sunkmann.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md.

Informant Charles Grant

(Address) West Port

Filed MAR 17 1927 E. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14 1927

17 I HEREBY CERTIFY, That I attended deceased from July, 1926, to March 14, 1927, that I last saw her alive on March 14, 1927, and that death occurred, on the date stated above, at 11:15 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. — mos. —

CONTRIBUTORY (Secondary) Dilatation of Heart.

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Urine

(Signed) Raymond V. Glaum, M. D.

March 15, 1927 (Address) Catonsville

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Western Cemetery | 3/17 1927 |
| 20 UNDERTAKER | ADDRESS |
| Ernest Lauchauer | 631 E. Pratt |

Spec.-7-17-26—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 20227

## CERTIFICATE OF DEATH

E 20227

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 110 N. Chapel, St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Bauer.

(a) RESIDENCE NO. 110 N. Chapel St. 6 Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S. if of foreign birth 46 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Bauer.

6 DATE OF BIRTH (month, day, and year) July 20th 1853

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|---|
| | 73 | 7 | 14 24 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Mfr

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany.
(State or country)

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (City or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Annie Bauer (Wife)
(Address) 110 N. Chapel St.

15 Filed MAR 17 1927 HARRY JONES, M. D. Registrar
Per R.H.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 14th 1927

17 I HEREBY CERTIFY, That I attended deceased from March, 1907, to March 14, 1927.

that I last saw him alive on March 12, 1927

and that death occurred, on the date stated above, at 5.45 p. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY Exhaustion.
(Secondary)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted —
if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy?

Were findings confirmed by Exam

(Signed) W. C. Hicks M. D.

3/17, 1927 (Address) 148 N. Ben

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Holy Redeemer Cemetery Mch 17 1927

20 UNDERTAKER Lilly & Zeiler ADDRESS 1038 Wash Ave

Cor.—12-9-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20228

CERTIFICATE OF DEATH.

74-001

E 20228

1-PLACE OF DEATH Franklin Sq. Hospital

City of BALTIMORE: (No. 16 Ward)

REGISTERED NO.

If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas. W. White

(a) RESIDENCE NO. 834 W. Fayette Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Vera L. White

6 DATE OF BIRTH (month, day, and year): July — 1884

7 AGE: Years 42; Months 8; Days —; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Foreman in Boiler Shop

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Bartlett & Hayward

9 BIRTHPLACE (city or town): Va

(State or country)

10 NAME OF FATHER: Chas T. White

11 BIRTHPLACE OF FATHER (city or town): Va

(State or country)

12 MAIDEN NAME OF MOTHER: Ella L. Jones

13 BIRTHPLACE OF MOTHER (city or town): Va

(State or country)

14 Informant: Vera L. White

(Address) 834 W. Fayette St

Filed ... 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mch 16th 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry) thereon and from the evidence obtained by Autopsy (Autopsy or Inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) — yrs. — mos. 1 hrs.

CONTRIBUTORY (Secondary) Chronic Hypertension

(Duration) ... yrs. ... mos. ... ds.

(Signed) Thos. B. Horton M. D.

(Coroner)

Mch 16th 1927 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See ...) Bal. Co. Md.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs., .....mos., .....ds. In the State.....yrs., .....mos., .....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Alexandria Va Date of Burial: May 1927

20 UNDERTAKER: Mc Nee. J. W. Teufel & Son ADDRESS: 801 W. Fayette

Filed APR 7 1927 E. HAYWARD JONES M. D.

Registrar

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20229

## CERTIFICATE OF DEATH

38 ✓ E 20229

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 613 W. Barre St., 22-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Jones.

(a) RESIDENCE NO. 613 W. Barre St. 22 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem.

4 Color or Race: Black Ed

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 69 Months — Days —

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (City or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mary Sorrell

(Address) 613 W Barre

Filed 1927, 19 E. FARLEY JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/15/1927

17 I HEREBY CERTIFY, That I attended deceased from 3/8/1927 to 3/15/1927

that I last saw her alive on 3/14/1927

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis (Fatal)

about (duration) ..... yrs. 3 mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Farley Jones M. D.

3/15/1927 (Address) 708 Druid Pk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion ct - Monday

Date of Burial 19

20 UNDERTAKER: S. A. Brown's Son

ADDRESS

Spec—12-23-21—E.B.R.S.—400 Bks.

Long.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20230

## CERTIFICATE OF DEATH.

E 20230

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1371 N. Calhoun 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura L. G. Long

(a) Residence No. 1371 N. Calhoun St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. — mos. — ds. How long in U. S., if of foreign birth? 59 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-If married, widowed, or divorced, HUSBAND of (or) WIFE of Gardner H Long

7-DATE OF BIRTH (month, day and year) Sept 4 1867

8-AGE. 59 yrs. 5 mos. 22 ds. If LESS than 1 day, ....hrs. or....min.?

9-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... House work
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037
(c) Name of employer.....

10-BIRTHPLACE (city or town) (State or Country), Md

10-NAME OF FATHER, John W. Hayes

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Eloraine —

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14-(Informant) Gardner H Long
(Address) 1371 Calhoun st

15-Filed 1 7 1927 C. HAMILTON JONES, M. D. Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 13/27

17- I HEREBY CERTIFY, That I attended deceased from Jan 1, 1927, to March 13, 1927, that I last saw h[illegible] alive on March 13, 19 27 and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:
Paralysis Cerebral Hemorrhage

(Duration) yrs. 2 mos. 13 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. 2 mos. 1½ ds.

18-Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) C. Hamilton Jones M. D

March 13 1927 (Address) 714 S Chapel

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL, March 17, 1927

20-UNDERTAKER, J. H. & J. Brown & Son — ADDRESS 1080 W. Pratt St

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20231

## CERTIFICATE OF DEATH.

100-001

13-59

E 20231

REGISTERED NO.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St. 13-59 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A.G. Howard

(a) RESIDENCE NO. 2126 Druid Hill Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Negro

5 Single, Married, Widowed, or Divorced. (write the word): Widowed

6a If ~~married~~, widowed, or ~~divorced~~ HUSBAND ~~or~~ WIFE of: Wesley Howard

6 DATE OF BIRTH (month, day, and year) ~~Feb~~ ? 1837

7 AGE: Years 90 ~~78~~ | Months ? | Days ? | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of Indnstry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Md.

(State or country)

10 NAME OF FATHER John Frahm

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Md

12 MAIDEN NAME OF MOTHER Mary —

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Md.

14 Informant: Records

(Address) BALTIMORE CITY HOSPITALS

15 Filed ... 19 ... Per ... Registrar

C. HAMPSON JONES, M. D.

7 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14 1927

17

I HEREBY CERTIFY, That I attended deceased from December 28, 1926, to March 14, 1927, that I last saw h.. alive on March 14, 1927, and that death occurred, on the date stated above, at 10 30 A m.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? General & laboratory

(Signed) R. Hooper Smith, M. D.

March 16 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — Date of Burial: Mar 17 1927

20 UNDERTAKER: W. M. Johnson — ADDRESS 1234 Eutaw St.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20232

## CERTIFICATE OF DEATH.

202 E 20232

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Sq. Hospital St. ____ Ward)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William G. Warfield

(a) RESIDENCE NO. 722 N. Gilmor St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colo

5 Single, Married, Widowed, or Divorced. (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 18 1870

7 AGE: Years 56 Months 4 Days 26 IF LESS than 1 day.....hrs. or.....min. 2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Wagon Driver

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer Wm D. Gilpin Inc.

9 BIRTHPLACE (city or town) (State or country): Cambridge Md

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

PARENTS

14 Informant: Gertrude Johnson

(Address) 722 N. Gilmor St

15 Filed ..... 19 .....

Per _____ Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by Inquest (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Jan 6/27

Mashed right foot — Became infected — Entered Hospital Feb 28/27 — Leg amputated above knee — on March 7/27

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) Thos. B. Horton M. D.

(Coroner)

March 16th 1927 (Address) Curtis Bay Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional data.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

Date of Burial: 3/17 1927

20 UNDERTAKER: Samuel T. Hawley

ADDRESS: Baltimore

Spec.—12-9-25—A Co.—200 Bks.

Mewberry

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20233

101-001

E 20233

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Bello City Hospital 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Wimbessey

(a) RESIDENCE NO. 1131 Shields Alley St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1903

7 AGE: Years 24; Months; Days; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Boxes

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Md

(State or country): Frederick

10 NAME OF FATHER: Louis Wimbessy

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Maryland

12 MAIDEN NAME OF MOTHER: Rosa Diggs

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): N. Carolina

14 Informant: Teresa Diggs

(Address) 605 Hollins St.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 3-14-1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 24, 1927, to 3-14, 1927 that I last saw him alive on 3-14, 1927 and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows: Pneumonia Lagrimale

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes Autopsy Laboratory

What test confirmed diagnosis? Bacteriological

(Signed) J. Bucevel M. D.

, 19 (Address) Bello City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem Date of Burial 3/18 19 27

20 UNDERTAKER: Samuel Brinsley ADDRESS 1128 N Bdle

Filed MAR 7 1927 H. A. JONES, M. D. Registrar

Per

Spec.—1-10-21—M&T—1500 Bks.

Newton Williams 129

# HEALTH DEPARTMENT—CITY OF BALTIMORE

20234

## CERTIFICATE OF DEATH.

E 20234

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 706 D.W. Ave ST. 17-24 WARD)

2-FULL NAME Newton Williams

(a) RESIDENCE NO. 706 D.W. Ave ST., WARD 9a

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | Married |

a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Clara Williams

DATE OF BIRTH (month, day, and year) 1856 1874

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 71 | | | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Public

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Va

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Alan Williams

(Address) 706 D.W. Ave

Filed 7-1927, 19 HARRY J. JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16 1927

17

I HEREBY CERTIFY, That I attended deceased from March 9th, 1927, to March 16, 1927.

that I last saw h[e] alive on March 16, 1927,

and that death occurred, on the date stated above at 10:30 P.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Nephritis chronic

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Le Gro, M. D.

(Address) 706 D.W. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: National Cem DATE OF BURIAL March 19 1927

20 UNDERTAKER Hamil Easton ADDRESS 516 Park

ec.—1-12-23—M&T—500 Blks.

E 20235

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 20235
REGISTERED NO.

1-PLACE OF DEATH St Josephs Hospital
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Caroline Abbot St. ST., 10-14 WARD)

2-FULL NAME Irene. Sawyer

(a) RESIDENCE NO. 1147. Greenmount ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: Colored.

5 Single, Married, Widowed, or Divorced, (write the word): Single.

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Feb. 8. 1919

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 8 | 0 | 14 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: school child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Newport News. Va.

10 NAME OF FATHER Fred. Sawyer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Norfolk. Va.

12 MAIDEN NAME OF MOTHER Ina. Gillian

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Richmond Va.

Informant Ella Sawyer
(Address) 1147 Greenmount

Filed 1927, 19 Per C. HAMILTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15 1927

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1927, to March 15, 1927, that I last saw her alive on March 15, 1927, and that death occurred, on the date stated above, at 3:00 p. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia.

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) meningitis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? none.

What test confirmed diagnosis? clinical.

(Signed) Clement K. Thomas, M. D.

3-16 1927 (Address) St Josephs Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel — DATE OF BURIAL: Mch 17 1927

20 UNDERTAKER: Sam W. Chase & Son — ADDRESS: 1400 Monroe

Cor.—12-9-25—A Co.—200 Blks.

E 20236

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

9 E 20236

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 20-7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Murray

(a) RESIDENCE NO. 529 N. Brice St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. 8 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| male | white | single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXX

6 DATE OF BIRTH (month, day, and year) July 13/26

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | | 8 | 3 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER James Murray

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Pa

12 MAIDEN NAME OF MOTHER Sadie R. Hall

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Hospital Records

(Address)

Filed MAR 17 1927 [illegible] Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 10/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia - Ototis Medi - Pertussis

(Autopsy at Hospital)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) [signature] M. D.

(Coroner)

3/10/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos., ds. In the State yrs. mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Hampden — Date of Burial 3/17 1927

20 UNDERTAKER Geo. Weber & Son — ADDRESS 2503 Edmondson

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 20237

REGISTERED NO. E 20237

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Balto City Hospt

City of BALTIMORE: (No. Balto Md 4-29 Ward)

2-FULL NAME Mattie Johnson

(a) RESIDENCE NO. 849 Oletend St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Black

5 Single, Married, Widowed, or Divorced: (Write the word) Single

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 38 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 10

(b) General nature of industry, business, or establishment in which employed (or employer): Domestic

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md

(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Balto City Hospt

(Address) Balto Md

15 Filed 4 7 1927 19 Per C. HAMILTON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-15 19 27

17 I HEREBY CERTIFY, That I attended deceased from 11-15 19 16 to 3-16 19 27, that I last saw her alive on 3-14 19 27, and that death occurred, on the date stated above, at 6.30 A. m.

The CAUSE OF DEATH was as follows: Cerebral Hemorrhage & Thrombosis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Dementia Vascular w/ Deterioration

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No signed mort

What test confirmed diagnosis? Clin Hist

(Signed) Brehm M. D.

(Address) Balto, Md 3/15/1927

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion cem

Date of Burial 3, 1927

ADDRESS 401

20 UNDERTAKER Mrs Geo A Hooper W Conway

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

10-901

E 20238

## CERTIFICATE OF DEATH

E 20238

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 945 Somerset St., 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph. F. Myers

(a) RESIDENCE NO. 945 Somerset St. 10 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. 2 mos. 8 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single. |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 29 1920

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min.. |
|---|---|---|---|---|
| | 6 | 2 | 18 | 8 |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Frederick L. Myers

11 BIRTHPLACE OF FATHER (City or town) Pa.
(State or country)

12 MAIDEN NAME OF MOTHER Helen M. Harmayer

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.
(State or country)

14 Informant M. Frederick L. Myers
(Address) 945 Somerset St

15 Filed 3/17 1927 (C. TAYLOR JONES M.D.) Registrar
Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 1927

17 I HEREBY CERTIFY, That I attended deceased from 3/14/27, 19..., to 3/17/27, 19...

that I last saw h alive on 3/17/27, 19...

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Pongaent Diphtheria

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Albert L. Levy M. D.

3/17/27 19 (Address) 628 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery Date of Burial March 18 1927

20 UNDERTAKER Henry Hardt Son ADDRESS 1301 E Eager St

E 20289 00 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002

## CERTIFICATE OF DEATH

E 20239

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 917 N. Eden St., 10th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary B. Segrist

(a) RESIDENCE NO. 917 N. Eden St. 10 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. \ mos. \ da. How long in U. S. If of foreign birth 71 yrs. mos. \ da.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: the late Jacob Segrist.

6 DATE OF BIRTH (month, day, and year): Dec. 6 1837

7 AGE: Years 89 Months 3 Days 10 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Conrad Steib

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Miss. Margaret Segrist.

(Address) 917 N. Eden St. Balto. Md.

Filed MAR 17 1927 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927: March 16.

17 I HEREBY CERTIFY, That I attended deceased from March 15th 1927, to March 16th 1927, that I last saw h. alive on March 16th 1927, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Cystitis Chronic

Senile Decay Hospital (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis 4 days

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo. E. Abell M. D.

(Address) 1501 E. Eager St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — Date of Burial: March 19 1927

20 UNDERTAKER: Henry Hoch Son — ADDRESS: 1011 E Eager St

Spec—12-23-21—E.B.R.S.—400 Eks.

# E 20240 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 20240

15-21/129

1-PLACE OF DEATH

Registered No.

City of BALTIMORE: (No. 1426 Prestman St. St.) 15-21/129 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maud M. Bush

(a) Residence No. 1426 Prestman St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6a-If married, widowed, or divorced HUSBAND of (or) WIFE of William W Bush

6-DATE OF BIRTH (month, day and year) Oct 19, 1885

7-AGE. 41 yrs. 5 mos. 4 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Employment agency

(b) General nature of industry, business, or establishment in which employed (or employer) Employment Bureau

(c) Name of employer Hansell's

9-BIRTHPLACE (city or town) (State or Country). Westernport Pennsylvania

10-NAME OF FATHER, Isaac Nash

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Virginia Cumberland Co

12-MAIDEN NAME OF MOTHER, Polly Anderson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Cumberland Co Virginia

14-(Informant) William W Bush

(Address) 1426 Prestman St

15-C. HARRY JONES, M. D.

Filed 1927 Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Mar 16 27

17- I HEREBY CERTIFY, That I attended deceased from March 10th 1927, to March 16 1927, that I last saw h alive on March 16 1927, and that death occurred, on the date stated above, at 6.30 a. m.

The CAUSE OF DEATH* was as follows: Pneumonia Nephritis

(Duration) yrs. 3 mos. 21 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Bonnell Fargo M. D.

19 (Address) 2937 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 20-PLACE OF BURIAL, CREMATION OR REMOVAL. | DATE OF BURIAL. |
|---|---|
| Mt Auburn Cemetery | 3/20 1927 |
| 20-UNDERTAKER. Mrs Chas. H. Dennis per T. O'Nelson | ADDRESS 1303 Prestman St |

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20241

## CERTIFICATE OF DEATH.

161-001

E 20241

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1378 W. Carey St. 15-23 WARD)

2-FULL NAME Henry Emmanuel Brown

(a) RESIDENCE NO. 1378 W. Carey ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Infant

6a If married, widowed, or divorced (HUSBAND of (or) WIFE of): Infant.

6 DATE OF BIRTH (month, day, and year): March 6. 1927

7 AGE — Years: — Months: — Days: 8 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ℓ

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: ℓ

9 BIRTHPLACE (city or town) (State or country): 1378 W. Carey St. Balto

PARENTS

10 NAME OF FATHER: Wilson Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Helen Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Helen Brown

(Address): 1378 W. Carey St

15 Filed MAR 7 1927 19 C. HAMPTON JONES, M. D. Registrar.

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 14 1927

17

I HEREBY CERTIFY, That I attended deceased from March 6, 1927, to March 14, 1927, that I last saw h alive on March 13, 1927, and that death occurred, on the date stated above, at 12 Noon m.

The CAUSE OF DEATH* was as follows:

Premature Birth.
(8 months foetus) Maternal
Influenza (duration) yrs. mos 8 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ℓ

Did an operation precede death? ℓ Date of

Was there an autopsy? ℓ

What test confirmed diagnosis? Physical

(Signed) Wm H Wright, M. D.

Mar 15, 1927 (Address) 1709 Presstman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery

DATE OF BURIAL: 3/17 1927

UNDERTAKER: Chas H. Dennis per T. B. Nelson

ADDRESS: 1303 Presstman

Sp—12-25—C—300 Bks.

E 20242

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 20242

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1910 McCulloh St. 14-20 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Monroe Jones

(a) RESIDENCE NO. 1910 McCulloh St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | Married |

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Rosa Jones

6 DATE OF BIRTH (month, day, and year) Dec 15, 1852

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 74 | 3 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butler (P)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Bedford Co. (State or country) Va.

PARENTS

10 NAME OF FATHER Schaduck Jones

11 BIRTHPLACE OF FATHER (city or town) Bedford Co (State or country) Va

12 MAIDEN NAME OF MOTHER Embrocum

13 BIRTHPLACE OF MOTHER (city or town) Va. (State or country)

14 Informant Rosie Jones

(Address) 1910 McCulloh St

15 Filed.....19.....

7-1927 Per _____ Registrar

C. HAMILTON JONES, M. D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15 1927

17

I HEREBY CERTIFY, That I attended deceased from March 8, 1927, to March 15, 1927, that I last saw h.. alive on March 15, 1927, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ___ yrs. ___ mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William Fales, M. D.

3/17, 1927 (Address) 1928 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Mt Auburn Cemetery | 3/18 1927 |

| 20 UNDERTAKER | ADDRESS |
|---|---|
| Mrs Jas H. Dennis and T. E. Kelson | 1303 Presstman St |

ec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

20243

## CERTIFICATE OF DEATH.

90 E 20243

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1621 Abbott ST., 713 WARD)

2-FULL NAME Mary Slechta

(a) RESIDENCE NO. 1621 Abbott ST., ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? 46 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widowe |

If married, widowed, or divorced HUSBAND of (or) WIFE of Casimir Slechta

DATE OF BIRTH (month, day, and year) Not Known

| AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 70 | | | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Bohemia

10 NAME OF FATHER Frank Zelnita

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

Informant Frank Slechta

(Address) 1621 Abbott St

Filed JUL 7 1927, 19 ..... By ..... C. HARRISON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 15 1927

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1927, to March 15, 1927, that I last saw him alive on March 14, 1927, and that death occurred, on the date stated above, at 7:30 A m

The CAUSE OF DEATH was as follows:

Mitral Regurgitation

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) auricular fibrillation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Fred Bruzelle M. D.

7-12-27 (Address) 600 N Wolfe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Mar 1927

20 UNDERTAKER Frank Erickson — ADDRESS 1906 Eastlake Ave

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20244

## CERTIFICATE OF DEATH.

24-33 +71-001

E 20244

REGISTERED NO.

1-PLACE OF DEATH South Balt Hosp

City of BALTIMORE: (No. 1213 S Light St Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Kenneth E. Stockwell

(a) RESIDENCE NO. Della Md St. Ward Della Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 27-1922

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 4 | 5 | 17 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Connecticutt

PARENTS

10 NAME OF FATHER John V. Stockwell

11 BIRTHPLACE OF FATHER (city or town)

(State or country) England

12 MAIDEN NAME OF MOTHER Rosa Heimerdinger

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Connecticutt

14 Informant Hospital Records

(Address)

Filed. 19 C. HARTSON JONES, M. D.

Per Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 March 16 27

17

I HEREBY CERTIFY, That I attended deceased from March 10, 1927, to March 16, 1927, that I last saw h.. alive on March 16, 1927, and that death occurred, on the date stated above, at 11 15 P m.

The CAUSE OF DEATH* was as follows:

Meningitis

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. B. Miller, M. D.

19 (Address) South Balt Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Johns Cem. Date of Burial Mar 19 27

20 UNDERTAKER Easton Sons ADDRESS Ellicott City

MAR 17 1927

ec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

20245

## CERTIFICATE OF DEATH.

11-00 E 20245

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2101 Clifton ave ST., 15-68 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophie Wolfson

(a) RESIDENCE NO. 2101 Clifton Av ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. — mos. — ds. How long in U. S., if of foreign birth? 18 yrs. — mos. — ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel

DATE OF BIRTH (month, day, and year) unknown

| AGE | Years | Months | Days | If LESS than 1 day, ... hrs or ... min. |
|---|---|---|---|---|
| | 75 | — | — | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Jacob Yoffenson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Stepie Yoffenson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

Informant (Address) Sarah Wolf 2101 Clifton ave

Filed MAR 17 1927 C. HARRY WILLIAMS Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 1927

17 I HEREBY CERTIFY, That I attended deceased from March 13, 1927, to March 16, 1927, that I last saw h[illegible] alive on March 16, 1927, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Influenza a Broncho-pneumonia with increasing heart weakness

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Senile Myocarditis

(duration) yrs. [illegible] mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical signs & Symptoms

(Signed) Franklin Smith, M. D.

(Address) 512 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Hebrew Hebrew Rest | 3/17 1927 |
| 20 UNDERTAKER | ADDRESS 1127 E Balto St |
| Joel Levinson & Bro | |

Spec.-7-17-26—A Co.—200 Bks.

E 20246

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

74001

E 20246

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 247 S. Durham St. 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. Houston

(a) RESIDENCE NO. 247 S. Durham St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | colored | widower |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1847

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 80 | | | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9 BIRTHPLACE (city or town) British
(State or country) West Indies

PARENTS

10 NAME OF FATHER unknown
11 BIRTHPLACE OF FATHER (City or town)
(State or country) unknown
12 MAIDEN NAME OF MOTHER unknown
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) unknown

14 Informant Stephen Tunstall
(Address) 247 S. Durham St

15 Filed MAR 17 1927 19 C. HARRISON JONES Registrar
Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 15 1927

17 I HEREBY CERTIFY, That I attended deceased from March 8th 1927 to March 15th 1927
that I last saw her alive on " " 1927
and that death occurred, on the date stated above, at 8.25 A. m.
The CAUSE OF DEATH* was as follows:

Paralysis

(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Apoplexy
(duration) yrs. mos. 1 ds.

18 Where was disease contracted
If not at place of death?
Did an operation precede death? no Data of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Jacob L. Johnson M. D.
3-15 1927 (Address) 308 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Laurel Cemetery | Mar. 17 19 27 |
| 20 UNDERTAKER Chas. N. Johnson & Bro. | ADDRESS Lovelyn St. |

Spec.—5-15-13—M. & T.—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20247

E 20247

## CERTIFICATE OF DEATH.

REGISTERED NO. C 17724

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1211 argyle ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elzobeth Cole

(Residence in Baltimore: No. 1211 argyle St.; 25 yrs.. mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ? (Month) (Day) 1870 (Year)

7-AGE, 57 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Nelson Griffin

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Margaret Snowden

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John R. Cole

(Address) 1211 Argyle Ave

15- Filed MAY 7 1927

C. HAMILTON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 3-14-27 (Month) (Day) 191... (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 23 192[illegible], to Mar 14 192[illegible], that I saw h[illegible] alive on 3-14-192[illegible], and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Gastritis

(Duration) yrs. 5 mo. ds.

CONTRIBUTORY (Secondary) Intest Tuberculosis

(Duration) 6 yrs. 7 mos. ds.

(Signed) W. P. Boykin M. D.

191... (Address) 16 1 S Carlton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn — DATE OF BURIAL, May 17, 1927

20-UNDERTAKER, Mrs. Geo. H. Holland — ADDRESS 631 Druid Hill Ave

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20248

## CERTIFICATE OF DEATH.

3 E 20248

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 918 Ashburton St. 16-68 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dora Morris

(a) RESIDENCE NO. 918 Ashburton St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): Widow.

5a If married, widowed, or divorced (or) WIFE of: John. P. Morris,

6 DATE OF BIRTH, (month, day, and year): January 10 " 1873

7 AGE: Years 54 | Months 2 | Days 5 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: house work.

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town)

(State or country): Va.

PARENTS

10 NAME OF FATHER: James. Wilkens

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Va

12 MAIDEN NAME OF MOTHER: Unknown.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Va.

14 Informant: Mrs. Hattie Stokes

(Address) 107 5th St. Brooklyn

Filed MAR 17 1927 HAROLD JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 15th 1927

17

I HEREBY CERTIFY, That I attended deceased from Dec 1, 1927, to March 15, 1927, that I last saw h.. alive on Mar 15, 1927, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY Exhaustion

(Secondary) Pulmonary Edema (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) G. S. Davis, M. D.

3/16, 1927 (Address) 804 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. Date of Burial 3/18/ 1927

20 UNDERTAKER: John F. Cowan & Son ADDRESS 901 Hollins St

Per John F. Cowan

Spec.—12-8-25—A Co.—200 Bks.

20249

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

51 E 20249

REGISTERED NO.

1-PLACE OF DEATH Sinai Hospital 12-59

City of BALTIMORE: (No. ____ St. ____ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Goldsmith

(a) RESIDENCE NO. 1 Granada Apts 4th St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Fifty yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Goldsmith

6 DATE OF BIRTH (month, day, and year): Nov 1859

7 AGE: 67 Years 6 Months 4 Days 15 IF LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Balto

(State or country) Md

10 NAME OF FATHER Casimir Wertheimer

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Germany

12 MAIDEN NAME OF MOTHER Henrietta Wertheimer

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Germany

14 Informant Joseph Goldsmith

(Address) 1 Granada Apts

Filed MAR 17 1927 C. HARRISON JONES M. D. Registrar

Per ____

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 16 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 8 1926, to March 16, 1927, that I last saw her alive on March 16, 1927, and that death occurred, on the date stated above, at 2:30 P.m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

(duration) ? yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Lobar pneumonia

(duration) ____ yrs. — mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Hist

(Signed) ____, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Sinai Friendship Gdns Cem — Date of Burial: March 18 26

20 UNDERTAKER: J Ahearn — ADDRESS: 334 Fulton Ave

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20250

## CERTIFICATE OF DEATH.

100-001

E 20250

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 510 S. Bouldin St. St., 26-2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas J. Schweiger.

(a) RESIDENCE NO. 510 S. Bouldin St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 24 - 1926

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | | 3 | 22 20 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child. do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Elmer Schweiger

11 BIRTHPLACE OF FATHER (city or town) Falls

(State or country) Md.

12 MAIDEN NAME OF MOTHER Maria Schech

13 BIRTHPLACE OF MOTHER (city or town) Falls

(State or country) Md.

14 Informant Elmer Schweiger.

(Address) 510 S. Bouldin St.

MAR 17 1927

[illegible] JONES, M. D.

Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16 - 1927

17 I HEREBY CERTIFY, That I attended deceased from 3/13, 1927, to 3/16, 1927, that I last saw h[illegible] alive on 3/15, 1927, and that death occurred, on the date stated above, at 6.55 a.m.

The CAUSE OF DEATH* was as follows:

Bronchitis.

(duration) yrs. 1 mos. 5 ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible] M. D.

3/16, 1927 (Address) 633-5 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Sacred Heart Cem. Mich. — Date of Burial 1927

20 UNDERTAKER — Lilly and Jiler — ADDRESS 403 S. Wolfe St.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90

20251

1-PLACE OF DEATH Belair Rd.

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

E 20251

City of BALTIMORE: (No. 3106 Lawnview Ave. 41 Ward)

2-FULL NAME John Fleischmann.

(a) RESIDENCE NO. 3106 Lawnview Ave. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? 44 yrs. _____ mos. _____ ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married.

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna Fleischmann.

6 DATE OF BIRTH (month, day, and year): Feb 13-1860

7 AGE: Years 67 | Months 1 | Days 3 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer. 040

(b) General nature of industry, business, or establishment in which employed (or employer): _____

(c) Name of employer: _____

9 BIRTHPLACE (city or town): _____

(State or country): Germany.

PARENTS

10 NAME OF FATHER: John Fleischmann.

11 BIRTHPLACE OF FATHER (city or town): _____

(State or country): Germany.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): _____

(State or country): Germany

14 Informant: Anna Fleischmann (Wife)

(Address) 3106 Lawnview Ave.

15 Filed _____ 19 _____ _____ Registrar

APR 7 1927 C. HE[illegible] JONES M.

Per _____

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: March 16-1927

17 I HEREBY CERTIFY, That I attended deceased from March 14, 1927, to March 15, 1927, that I last saw him alive on March 15, 1927, and that death occurred, on the date stated above, at 12.05 a. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) 3 yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) Terminal Edema of right lung

(duration) _____ yrs. _____ mos. 12 hours ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Harry B Athey, M. D.

3/16, 1927 (Address) 2504 E. Pratt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cem. Date of Burial: March 18 1927

20 UNDERTAKER: Lilly & Zeiler ADDRESS: 703 S. Wolfe St.

Spec.—12-9-25—A Co.—200 Pks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20252

11-001

## CERTIFICATE OF DEATH.

E 20252

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3700 Foster Ave St., 1-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leo F. Winterling

(a) RESIDENCE NO. 3700 Foster Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Winterling

6 DATE OF BIRTH (month, day, and year): July 17-1890

7 AGE — Years: 36 | Months: 7 | Days: 27 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: [illegible]

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md.

PARENTS

10 NAME OF FATHER: Constantine Winterling

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Germany.

12 MAIDEN NAME OF MOTHER: Christina Grotzmann

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Germany.

14 Informant: Mary Winterling

(Address) 3700 Foster Ave.

15 Filed ..... 19 .....

Registrar

Deputy

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 March 5- 1927

17 I HEREBY CERTIFY, That I attended deceased from 3/3/27, 19..., to 3/14, 19 27

that I last saw h.. alive on 3/14, 19 27,

and that death occurred, on the date stated above, at 1.30 A.M.

The CAUSE OF DEATH* was as follows:

Influenza

Labor Pneumonia

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY

(Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted — If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) J. H. Garrell, M. D.

3/16, 1927 (Address) 633-2-34

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cem. Mich 18 — Date of Burial 1927

20 UNDERTAKER: Tilly and Zirler — ADDRESS: 403 S. Wolfe St.

Spec.—7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20253

## CERTIFICATE OF DEATH

52 ✓

E 20253

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. University Hosp. St. 13-52 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ethel M. Wheat.

(a) RESIDENCE NO. 3732 Chestnut Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) Dec 7, 1915.

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 11 | 3 | 10 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER Robert H. Wheat.

11 BIRTHPLACE OF FATHER (City or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Ethel M. Russell

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Robert H. Wheat.

(Address) 3732 Chestnut Ave.

Filed 1 7 1927 C. HAMILTON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 17 1927.

17 I HEREBY CERTIFY, That I attended deceased from Mar. 16, 1927, to Mar 17, 1927

that I last saw her alive on Mar 17, 1927

and that death occurred, on the date stated above, at 2:40 A. m.

The CAUSE OF DEATH* was as follows:

Rheumatic Cardiovascular disease

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) yrs. 3 mos. ds.

18 Where was disease contracted

If not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. K. Muller, M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — Date of Burial March 19 27

20 UNDERTAKER Ebenezer Lee — ADDRESS 3417 Chestnut Ave

Spec.—12-9-25—A Co.—200 Bks.

Ann M. Mc Donough

100-001

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20254

## CERTIFICATE OF DEATH.

E 20254

1-PLACE OF DEATH

City of BALTIMORE: (No.) Roche Park Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ann M. Mc Donough

(a) RESIDENCE Roche Park Hospital Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 Color or Race W

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or ~~divorced~~ ~~HUSBAND of~~ (or) WIFE of J. J. Mc Donough

6 DATE OF BIRTH (month, day, and year) — — 1854

7 AGE

| Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|
| 73 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Thomas Tracey

11 BIRTHPLACE OF FATHER (City or town) Baltimore

(State or country) Md

12 MAIDEN NAME OF MOTHER Ann ?

13 BIRTHPLACE OF MOTHER (City or town) Baltimore

(State or country) Md

14 Informant J. J. Mc Donough

(Address) Roche Park Hospital

15 Filed MAR 17 1927 C. HAMILTON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 27

Mch 16 1927

17

I HEREBY CERTIFY, That I attended deceased from Mch 12 1927, to Mch 16, 1927, that I last saw h[illegible] alive on Mch 15, 1927, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

1 Broncho Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted Home

If not at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Charles J Wells, M. D.

, 19 (Address) 5242 Park Heights Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Catholic Cem.

Date of Burial 3/19 19 27

20 UNDERTAKER J. F. Fahey & Sons

ADDRESS 5182 Eight St.

(Bryant)

Spec.-7-17-26-A Co.-200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20255 E 20255

## CERTIFICATE OF DEATH

90

1-PLACE OF DEATH Colonial Hospital REGISTERED NO. 4-70

City of BALTIMORE: (No. 1122 W. Mount St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clyde Bryant

(a) RESIDENCE NO. 564 McMechen St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | colored | Married |

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Essie Bryant

6 DATE OF BIRTH (month, day, and year) Dec. 17 ?, 1890

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 36 | 2? | 29? | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor &

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town)

(State or country) N.C.

PARENTS

10 NAME OF FATHER Not stated

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Not stated

12 MAIDEN NAME OF MOTHER Dora Smith

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) N.C.

14 Informant Essie Bryant (Wife)

(Address) 533 McMechen St.

15 1927 C. HAMPSON JONES, M. D.

Registrar

Per NRA

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/16 1927

17 I HEREBY CERTIFY, That I attended deceased from 3/11, 1927 to 3/16, 1927.

that I last saw h.e alive on 3/10, 1927.

and that death occurred, on the data stated above, at 9:30 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Myocarditis

? (duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted ?

If not at place of death?

Did an operation precede death? No Data of

Was there an autopsy? No

What test confirmed diagnosis? Phys. exam

(Signed) John D. Graham, M. D.

, 19 (Address) 1122 W. Mount St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL La Grange, N.C. Date of Burial Mar 17 1927

20 UNDERTAKER Jno. M. Johnson ADDRESS 1217 E. Lanvale St.

Spec.—8-24-14—M. & T.—2000 Bks.

E 20256

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20256

## CERTIFICATE OF DEATH.

REGISTERED No. C 17-290

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 516 St. Mary ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Tankard

(Residence in Baltimore: No. 516 St. Mary St.; 35 yrs., mos. da.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, May 17, 1874 (Month) (Day) (Year)

7-AGE, 52 yrs. 11 mos. 28 ds.

If LESS than 1 day, ....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, William Tankard

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Maria Kellum

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henrietta Tankard (Wife)

(Address) 1350 Carroll St.

15- C. HAMPSON JONES, M. D.

Filed....., 191.....

MAY 7 1927 Per ..... Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 15, 1927 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 1 1927, to May 15 1927, that I saw h[illegible] alive on March 15 1927, and that death occurred, on the date stated above, at 12:45 m.

The CAUSE OF DEATH* was as follows:

(a) Cardiac Decompensation

.....

.....

..... (Duration) ....yrs. ....mos. 15 ds.

CONTRIBUTORY (Secondary) C. V. D. Hypertension

..... (Duration) ....yrs. ....mos. 15 ds.

(Signed) Charles H. Thomas M. D.

March 15 1927 (Address) 712 Dr. Eye Hosp. Bldg.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cemetery

DATE OF BURIAL, May 18, 1927

20-UNDERTAKER John M. Johnson

ADDRESS 1334 E. Thirty-First

Cor.—12-9-25—A Co.—200 Bks.

E 20257

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20257

## CERTIFICATE OF DEATH.

167-681

23-31

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 918 Hanover St. St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Solomon Messick.

(a) RESIDENCE NO. 918 Hanover St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male. | White. | Widower. |

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Ella E. Messick.

6 DATE OF BIRTH (month, day, and year) Do not know.

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 76 | -------- | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Cambridge, Md.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Do not know.

14 Informant Elmer E. Messick. (son)

(Address) 1256 Riverside Ave.

15 1927 C. HAMPSON JONES, M. D. Registrar

Per

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Illuminating gas asphyxia.
Suicide.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) (duration) .....yrs. .....mos. .....ds.

(Signed) Otto Reinhardt M. D.
(Coroner)

3/17, 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Date of Burial Mar 17 1927

20 UNDERTAKER Wm Ecroth ADDRESS 502 E Fayette Ave.

Cor.—12-9-25—A Co.—200 Bks.

THE MORGUE.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20258

CERTIFICATE OF DEATH.

66 E 20258

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Abermarle & Pratt St. 3-5 Ward)

2-FULL NAME Jacob Morton

(a) RESIDENCE NO. Abermarle St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown How long in U. S., If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced. (write the word): M K

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) — 1867

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 60 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Unk

(State or country)

PARENTS

10 NAME OF FATHER N K.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) N K.

12 MAIDEN NAME OF MOTHER N K

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) N K

14 Informant C B. Silver

(Address) Havre de Grace Md.

15 Filed 1927 Registrar

THE MORGUE

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Alcoholism

(duration) yrs. mos. 1 ds.

Exhaustion

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 1 ds.

(Signed) May 7, 1927 C C Yates M. D.

(Coroner)

(Address) 143 N Kenrig

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rock Run Harford Co. Md. Date of Burial May 1927

20 UNDERTAKER T Madison Mitchell ADDRESS Havre de Grace Md.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20259

## CERTIFICATE OF DEATH.

113 E 20259

1-PLACE OF DEATH

City of BALTIMORE: (No. 1714 Riggs Ave St., 16 27 Ward)

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis Nelson

(a) RESIDENCE NO. 1714 Riggs Ave St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male | 4 Color or Race: colored | 5 Single, Married, Widowed, or Divorced. (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) about Feb. 12, 1927

7 AGE: Years | Months | 27 Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant W. W. Foley Dist. (Address) Same as above

Filed 1927 Registrar

Per

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Sepsis

(duration) yrs. mos. ds.

(Signed) O. T. Hennessy M. D.

(Coroner)

19 27 (Address) 350 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial 19

20 UNDERTAKER | ADDRESS

1927 C. HAMPSON JONES, M. D.
UNIVERSITY OF MARYLAND.
Commissioner Health.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20260

E 20260

## CERTIFICATE OF DEATH.

118-002

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore General Hospital St. 24-33 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Wilford.(C)

(a) RESIDENCE NO. Do not know. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male. | Colored | Do not know. |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) Do not know.

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 56 | --- | --- | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laboeer

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) Do not know.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Do not know.

14 Informant Police Report. S. D.

(Address) UNIVERSITY OF MARYLAND

15 Filed 1927 C. HAMSON JONES, M. D. Registrar

Per _____

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction.

Peritonitis.

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) _____

(duration) ___ yrs. ___ mos. ___ ds.

(Signed) Otto M. Steinhardt M. D.

(Coroner)

3/17 1927 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ___ yrs., ___ mos., ___ ds. In the State ___ yrs., ___ mos., ___ ds.

Where was disease contracted, if not at place of death?_____

Former or usual residence_____

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND Date of Burial 19

20 UNDERTAKER [illegible] ADDRESS [illegible]

MAR 5 1927

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20261

## CERTIFICATE OF DEATH.

129 E 20261

1-PLACE OF DEATH

City of BALTIMORE: (No. 103 S. Washington St. 7-4 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara Schmidt

(a) RESIDENCE NO. 103 S. Washington St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. __ mos. __ ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: late Frederick Schmidt

6 DATE OF BIRTH (month, day, and year): May 2/48

7 AGE — Years: 78 — Months: 10 — Days: 13 — If LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): (State or country) Germany

PARENTS

10 NAME OF FATHER: Hess

11 BIRTHPLACE OF FATHER (city or town): (State or country) Germany

12 MAIDEN NAME OF MOTHER: Hahnemann

13 BIRTHPLACE OF MOTHER (city or town): (State or country) Germany

14 Informant: Mrs Geo. Kercher

(Address) 103 S. Washington St

15 Filed _____, 19__ C. HAMPSON JONES, M. D. Registrar

7 1927 Per CHJ

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/15/27

17 I HEREBY CERTIFY, That I attended deceased from Feb 20, 19 27, to March 15, 19 27, that I last saw h.. alive on March 15, 19 27, and that death occurred, on the date stated above, at 12 M. a.m.

The CAUSE OF DEATH* was as follows:

Chr Cardiac valvular Disease

Arteriosclerosis (Senile)

Chr-nephritis (?)

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Leukemia

(duration) ____ yrs. ____ mos. 3 ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? No Date of ____

Was there an autopsy? No

What test confirmed diagnosis? ____

(Signed) Emil J Zeigler, M. D.

3/16, 19 27 (Address) 1401 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — Date of Burial 3/18 19 27

20 UNDERTAKER: Philip Henry — ADDRESS 3016 Orleans St

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20262

CERTIFICATE OF DEATH.

90 E 20262

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Mercy Hospital

City of BALTIMORE: (No. _____ St. 47 Ward)

2-FULL NAME Edward Wagner

(a) RESIDENCE NO. 327 N. Gay St. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| M | W | Single. |

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May. 1865

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 61 | 10 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Photographer

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.

(State or country)

PARENTS

10 NAME OF FATHER John F. Wagner

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER M. Schafer

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mr. John M. Wagner

(Address) 327 E. Gay St.

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 13, 1926, to March 15, 1927

that I last saw h.. alive on March 15, 1927

and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial degeneration

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Physician, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore, Md. Date of Burial 3/18/1927

20 UNDERTAKER M. M. Wiedefeld. ADDRESS 57 E. 25th

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20263

## CERTIFICATE OF DEATH

24-01 E 20263

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1917 Eutaw Place St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matilda Herman

(a) RESIDENCE NO. 1917 Eutaw Place. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 25th. 1852.

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 74 | 2 | 22 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Maryland.

PARENTS

10 NAME OF FATHER Daniel Herman.

11 BIRTHPLACE OF FATHER (City or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Lena Bowman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Miss. Herman (Address) 1917 EutawxPlace

15 Filed 7 1927 C. HARRISON JONES, M. D. Registrar Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/17/ 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 15, 1926, to March 17, 1927, that I last saw her alive on March 17, 1927, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis

(duration) 5 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) cerebral-hemorrhage

(duration) yrs. 6 mos. ds.

18 Where was disease contracted

If not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Fred Lee, M. D.

3/17. 1927 (Address) Temple Garden Apts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Crematory. Date of Burial 3/18/ 1927

20 UNDERTAKER David Sondheim ADDRESS 115-20 W. Mt. Royal Ave

Spec—12-23-21—E.B.R.S.—400 Eks.

E 20264

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20264

## CERTIFICATE OF DEATH.

101-201

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 1412 N Patterson Park Ave St. 8-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lydia Taylor Burns

(a) Residence No. 1412 N Patterson Park Ave St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write this word.): Single

6a-If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6-DATE OF BIRTH (month, day and year) Nov 11 1878

7-AGE: 48 yrs. 4 mos. 5 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Shirt Operator
(b) General nature of industry, business, or establishment in which employed (or employer): Shirt Mfg.
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore Maryland

PARENTS:
10-NAME OF FATHER: John T. Burns
11-BIRTHPLACE OF FATHER (city or town) (State or Country): Maryland
12-MAIDEN NAME OF MOTHER: Susan Archer
13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Easton Md Maryland

14-(Informant) Lena Reynolds
(Address) 1412 N Patterson Park Ave

15-Filed 1927 C. HAMPSON JONES, M. D. Registrar.
Per

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): March 16 27

17- I HEREBY CERTIFY, That I attended deceased from March 13, 1927 to March 16, 1927.
that I last saw h.er alive on March 15 1927
and that death occurred, on the date stated above, at 7 45 A M.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary) Oedema of Lungs
(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) E. Gill Hall M. D.
March 17, 1927 (Address) 1631 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery
DATE OF BURIAL: March 19, 1927

20-UNDERTAKER: Hughes & Sons Inc
ADDRESS: 1410 N Broadway

Spec– 12-23-21—E.B.R.S.—400 Bks.

E 20265

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20265

## CERTIFICATE OF DEATH.

Registered No. 90

1-PLACE OF DEATH

City of BALTIMORE: (No. 2738 Maryland Ave St. 12-51 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Elizabeth Smith

(a) Residence No. 2736 E Maryland Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 7 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

6-If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas A Smith

7-DATE OF BIRTH (month, day and year) Aug 10 1855

8-AGE. 71 yrs. 8 mos. 6 ds.

If LESS than 1 day, ....hrs. or....min.?

9-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

10-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS

10-NAME OF FATHER, Thomas Thompson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Elizabeth Davis

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Mrs Watts

(Address) 2736 Maryland Ave

15- Filed 1927 C. HAMPSON JONES, M. D. Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Mch 16, 27

17- I HEREBY CERTIFY, That I attended deceased from Mar 15, 1927, to Mar 16, 1927, that I last saw h.. alive on Mar 15, 1927, and that death occurred, on the date stated above, at 12:05 m.

The CAUSE OF DEATH* was as follows:

Organic heart disease (mitral incomp.)

(Duration) ...yrs. 12 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 5 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physician

(Signed) Chas J Keller M. D.

3/17, 1927 (Address) 222 W Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19-PLACE OF BURIAL, CREMATION OR REMOVAL. | DATE OF BURIAL. |
|---|---|
| Loudon Cemetery | Mch 18, 1927 |
| 20-UNDERTAKER. | ADDRESS |
| Hughes & Sons Inc | 414 N Broadway |

Spec.-7-17-26—A Co.—200 Bks.

E 20266

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

10 E 20266

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1200 Longwood St. 16-67 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Robert Hertz

(a) RESIDENCE NO. 1200 Longwood St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) January 16, 1922

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min.. |
|---|---|---|---|---|
| | 5 | 2 | 1 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Maryland

PARENTS

10 NAME OF FATHER David E. Hertz,

11 BIRTHPLACE OF FATHER (City or town) Newport
(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Esther Shirk

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pennsylvania

14 Informant David E. Hertz,
(Address) 1200 Longwood Street

15 Filed 3-17 1927 C. HAMPSON JONES, M. D. Registrar Per RRW

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17, 1927

17 I HEREBY CERTIFY, That I attended deceased from March 13, 1927, to March 17, 1927, that I last saw him alive on March 17, 1927, and that death occurred, on the date stated above, at 6.45 a. m.

The CAUSE OF DEATH* was as follows:

Hospitalism, 5 d.
Thrombosis of Lt. Internal Jugular Vein, 4 d.
Streptococcic Septicemia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Tuberculosis of Cervical Glands

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

(Address) 709 North Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — Date of Burial Mar. 18 1927

20 UNDERTAKER Capt. H. Cook — ADDRESS 1003 North

Spec. -7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

20267

## CERTIFICATE OF DEATH

49 E 20267

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 2029 Frederick St. 20-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma V Schach

(a) RESIDENCE NO. 2029 Frederick St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. 9 mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married. |

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~—~~ (or) WIFE of William Schach

6 DATE OF BIRTH (month, day, and year) June - 15 - 1866

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|---|
| | 60 yrs. | 9 mo. | 0 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Nelson Blunt.

11 BIRTHPLACE OF FATHER (City or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Cooper.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Harry Haven.

(Address) 2029 Frederick Ave.

7 1927 C. HAMPSON JONES, M. D. Registrar

Per ARCH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 15, 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 31, 1927, to Mar 15, 1927, that I last saw h[er] alive on Mar 15, 1927, and that death occurred, on the date stated above, at 8[19] P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder (duration) yrs. 1 mos. 11 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema (duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Cystoscopic Ex

(Signed) [illegible] M. D.

3/15 1927 (Address) 1724 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery. Date of Burial Mar. 18 1927

20 UNDERTAKER Charles J. Schwab. ADDRESS 505 N. Monroe St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20268

## CERTIFICATE OF DEATH.

101,001

E 20268

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3417 Old Frederick Road (WARD) 20-10

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Phillip H. McAleer,

(a) RESIDENCE. No. 3417 Old Frederick Road WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. 5 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or WIFE of): Catherine L. McAleer

6 DATE OF BIRTH (month, day, and year): Sept. 9-1847

7 AGE: Years 79 Months 5 Days 7 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Telegraph Operator

(b) General nature of industry, business, or establishment in which employed (or employer): Railroad

(c) Name of employer: Baltimore & Ohio

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: John McAleer

11 BIRTHPLACE OF FATHER (city or town) (State or country): York, Pa.

12 MAIDEN NAME OF MOTHER: Ann Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Mrs. Ella Rudolph, 1059 Riggs St.

15 Filed 1 7 1927 C. HAMPSON JONES, M. D. Registrar

Per Act

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/16 1927.

17 I HEREBY CERTIFY, That I attended deceased from 2/12, 1927, to 3/16, 1927, that I last saw h[im] alive on 3/16/27, 19, and that death occurred, on the date stated above, at 8.45 A. m.

The CAUSE OF DEATH* was as follows:

General Senile Arteriosclerosis
Cystitis, hypertrophy prostate

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Lobar pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 3417 Old Frederick

Did an operation precede death? No Date of 3/16/27

Was there an autopsy? No

What test confirmed diagnosis? Findings.

(Signed) Damian P. Gadzia M. D.

, 19 (Address) 3376 Frederick Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery

DATE OF BURIAL: Mar. 18-1927

20 UNDERTAKER: J. H. Offutt, Jr.

ADDRESS: 3805 Monastery Ave.

TION IS VERY Important. See instructions on back of Certificate.

Spec.—12-9-25—A Co.—200 Bks.

E 20269

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 20269

1-PLACE OF DEATH Mercy Hospital

REGISTERED NO. 101-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. ) St. W-7 (Ward)

2-FULL NAME Charles Cooney

(a) RESIDENCE NO. Ellicott City Md. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Catherine Cooney.

6 DATE OF BIRTH (month, day, and year): 1863

7 AGE: 63 Years | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country) Maryland.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town):

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town):

(State or country)

14 Informant Hospital Records

(Address)

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 27

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1927, to March 17, 1927, that I last saw h— alive on March 17, 1927, and that death occurred, on the date stated above, at 11:45 a.m.

The CAUSE OF DEATH* was as follows:

Cerebro Sclerosis

Myocardial Degeneration

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death!

Did an operation precede death! Date of

Was there an autopsy!

What test confirmed diagnosis!

(Signed) R. M. Wolfe, M. D.

. 19 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem. Date of Burial: Mar. 19, 1927

20 UNDERTAKER: Easton Doan ADDRESS: Ellicott City

Spec.—6-9-19—H. P. Co.—1000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20270 E 20270

## CERTIFICATE OF DEATH.

24-34

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1735 Covington ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. Winslow McGonigle.

(a) RESIDENCE No. 1735 Covington ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male. | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 13. 1922

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 0 | 9 | 4 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Harry D. McGonigle.

11 BIRTHPLACE OF FATHER (city or town) Howard County. Md
(State or country)

12 MAIDEN NAME OF MOTHER Golden Johnson

13 BIRTHPLACE OF MOTHER (city or town) Howard County. Md
(State or country)

14 Informant Mrs. Mc Gonigle
(Address) 1735 Covington

15 Filed 3 18 1927 C. HAMILTON JONES, M. D. Registrar
Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 17 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 17, 1927, to Mar. 17, 1927, that I last saw him alive on Mar. 17, 1927, and that death occurred, on the date stated above, at 11 45 A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia.

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Whooping cough.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no.

What test confirmed diagnosis? post

(Signed) W. T. Slabey, M. D.

3/17, 1927 (Address) 636 Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem

DATE OF BURIAL 3/18 1927

20 UNDERTAKER J. Flew McCully

ADDRESS 130 E Fort

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20271 101-001 E 20271

## CERTIFICATE OF DEATH

REGISTERED NO. [redacted]

1-PLACE OF DEATH

City of BALTIMORE: (No.) Provident Hospital St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emmet Morgan

(a) RESIDENCE NO. 162 Colvin St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | C | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emmet Morgan

6 DATE OF BIRTH (month, day, and year) Unknown 1889

7 AGE Years 36 Months Days IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ft Texas

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town) Unknown

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown

(State or country)

14 Informant Elsie Collins

(Address) 307 Forest st.

15 Filed MAR 19 19 C. HARRISON JONES, M. Registrar

Per [illegal] Morgue

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 10 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 7, 1927, to Mar 10, 1927,

that I last saw him alive on Mar 9, 1927,

and that death occurred, on the date stated above, at 7:5 A m.

The CAUSE OF DEATH* was as follows: Lobar Pneumonia.

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY

(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted ?

If not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Signs

(Signed) John B Garnett, M. D.

. 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Calvary Date of Burial Mar 18, 1927

UNDERTAKER Mrs. P. A. Elliott ADDRESS Catonsville

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20272

## CERTIFICATE OF DEATH.

90

REGISTERED NO. E 20272

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 3618 Dillon St. 26-37 Ward)

2-FULL NAME Dafney Brown

(a) RESIDENCE NO. 3618 Dillon St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Colored | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1871

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 56 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 37

(b) General nature of industry, business, or establishment in which employed (or employer) House wife

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Va.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) unknown

14 Informant Joseph Brown

(Address) 3618 Dillon St

15 Filed ..... 19 C. HAMPTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 15 1927

17

I HEREBY CERTIFY, That I attended deceased from Mar 13, 1927, to Mar 15, 1927, that I last saw h.. alive on Mar 13, 1927, and that death occurred, on the date stated above, at 1 30 m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

Idiopathic (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY Cardiac asthma (Secondary)

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. Edward Fisher, M. D.

3-15. 1927 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Asbury Cemetery Mar 18 1927

20 UNDERTAKER Mrs. A. G. Elliott ADDRESS 1725 Eastlan[illegible]

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20273

## CERTIFICATE OF DEATH.

E 20273

1-PLACE OF DEATH — CITY OF BALTIMORE: (No.) 6 Biddison Lane (St.) Raspburg (Ward) 27-41

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Newmeister

(a) RESIDENCE No. 6 Biddison Lane St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Chas G Newmeister

6 DATE OF BIRTH (month, day, and year): June 19, 1863

7 AGE: Years 63 Months 8 Days 28 (26)

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balti. Md

PARENTS

10 NAME OF FATHER: L. Grimm

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balti Md

12 MAIDEN NAME OF MOTHER: Evelin Lantz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balti Md

14 Informant: Harry L Hoey

(Address) 10 Stacey Court Balto

15 Filed APR 18 1927 By: HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 17 1927

17 I HEREBY CERTIFY, That I attended deceased from Feby 14 1927 to March 17 1927

that I last saw h alive on March 17 1927

and that death occurred, on the date stated above, at 11.30 A m.

The CAUSE OF DEATH* was as follows: Chronic Bronchitis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) 15 yrs. 9 mos. 1 ds.

18 Where was disease contracted, if not at place of death? Hemorrhage brain

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm Stonge M. D.

3/17, 1927 (Address) Cross & Southern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery — DATE OF BURIAL: March 21 1927

20 UNDERTAKER: Frank Lassahn & Sons — ADDRESS: Fulsarton

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20274

## CERTIFICATE OF DEATH.

E 20274

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2236 Mondawmin ave ST., 13-59 90 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachael Gordon

(a) RESIDENCE NO. 2236 Mondawmin ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| F | white | widow |

6 If married, widowed or divorced, HUSBAND of (or) WIFE of Louis Gordon

DATE OF BIRTH (month, day, and year) 1856

| AGE | Years | Months | Days | If LESS than 1 day, ....hrs. or.....min. |
|---|---|---|---|---|
| | 71 | — | — | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Isaac Gromer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rose —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

Informant Paul Gordon

(Address) 2236 Mondawmin ave

Filed 8 1927 19 CHARLES JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/17 1927

17

I HEREBY CERTIFY, That I attended deceased from March 15, 1927 to Mar. 17, 1927, that I last saw h er alive on Mar. 17 1927 and that death occurred, on the date stated above, at 5:50 m

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Mitral Stenosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) S. Wolman, M. D.

3-17 1927 (Address) 2444 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship DATE OF BURIAL 3/18 1927

20 UNDERTAKER Jack Lewis ADDRESS 1438 E Balto st

Spec.—12-9-25—A Co.—200 Bks.

E 20275

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20275

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. ~~JOHNS HOPKINS HOSPITAL~~ St. 59 Ward)

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Henry Tracey

(a) RESIDENCE NO. 1413 E. Baltimore St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (write the word) |
|---|---|---|
| Male | Col - | Single |

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 16-1925

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 1 | 3 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9 BIRTHPLACE (city or town).....

(State or country) Md.

PARENTS

10 NAME OF FATHER Charles Tracey

11 BIRTHPLACE OF FATHER (city or town).....

(State or country) Delaware,

12 MAIDEN NAME OF MOTHER Estelle Sims

13 BIRTHPLACE OF MOTHER (city or town).....

(State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

FILED MAR 18 1927 19 C. HAMPSON WHITE, M. D. Registrar.

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 16 1927

17

I HEREBY CERTIFY, That I attended deceased from 13 Mar., 1927, to 16 March, 1927, that I last saw him alive on 16 March, 1927, and that death occurred, on the date stated above, at 11:20 a. m.

The CAUSE OF DEATH* was as follows:

Primary Bronchopneumonia

(duration) .....yrs. .....mos. 7 .....ds.

CONTRIBUTORY .....
(Secondary)

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted

If not at place of death! Residence

Did an operation precede death! No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Clinical observation

(Signed) H. E. Handley, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Asbury cemetery Mar 19 1927

20 UNDERTAKER Edward Bryan ADDRESS 1631 Orleans st

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20276

## CERTIFICATE OF DEATH.

38 E 20276

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 313 Delaware Ave. ST., 26 WARD) 76-42 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie E. Wright

(a) RESIDENCE NO. 313 Delaware Ave. ST., 26 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edwin W. Wright

6 DATE OF BIRTH (month, day, and year) April 6, 1857

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 69 | 11 | 11 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Charles Groome

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Maryland

12 MAIDEN NAME OF MOTHER Julia Gefhardt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Edwin W. Wright

(Address) 313 Delaware Avenue

15 Filed 1 8 1927 19 [illegible] Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16, 1927

17

I HEREBY CERTIFY, That I attended deceased from March 13, 1927 to March 16, 1927

that I last saw her alive on March 16, 1927

and that death occurred, on the date stated above, at 5 [illegible] m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) Many yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Tertiary Syphilis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. L. Wilkinson, M. D.

3/17 1927 (Address) 13 N. Belair Rd. Haspeburg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL March 19 19 27

20 UNDERTAKER William Cook — ADDRESS 502 E. North Avenue

Spec.—1-12-23—M&T—500 Bks.

E 20277

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

101-001

E 20277

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 125 Buckland Ave ST. 27-43 WARD)

2-FULL NAME Elmer Benjamin Knepshield

(a) RESIDENCE NO. 125 Buckland ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX M | 4 COLOR OR RACE W | 5 Single, Married, Widowed, or Divorced, (write the word) Single.

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Dec 15, 1922

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 4 | 3 | 2 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Royal A. Knepshield

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Sadie M Livingston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Royal A Knepshield

(Address) 125 Buckland Ave.

Filed 1927 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/17/1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 3, 1927, to Mar 17, 1927, that I last saw h alive on Mar 17, 1927, and that death occurred, on the date stated above, at 7.50 m.

The CAUSE OF DEATH* was as follows: Lobar Pneumonia A

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) others unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Carl Jones, M. D.

(Address) 4 W 86 Hopkins Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Forkwood. DATE OF BURIAL March 20 1927

20 UNDERTAKER W. M. Cook ADDRESS 503 E North Ave

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20278

CERTIFICATE OF DEATH

E 20278

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 409 E 31st St. 12-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy M Aler

(a) RESIDENCE NO. 409 E 31st St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | W. | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of David A. Aler

6 DATE OF BIRTH (month, day, and year) Sept 9. 1850

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..hrs. or ..min.. |
|---|---|---|---|---|
| | 76 | 6 | 7 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER Joseph Allison

11 BIRTHPLACE OF FATHER (City or town) Pa

(State or country)

12 MAIDEN NAME OF MOTHER Mariah L Hall.

13 BIRTHPLACE OF MOTHER (City or town) Balto

(State or country) Md.

14 Informant Mrs Lillie Gardner

(Address) 409 E 31st St

15 Filed 8 1927 C. HARRISON JONES, M. D. Registrar

Par

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 16 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 23 1924 to Mar 16 1927

that I last saw h alive on Mar 15 1927

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 2 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Gen. Carcinomata

(duration) yrs. 6 mos ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Sub.

(Signed) C. Harrison Jones, M. D.

3-17 1927 (Address) 5600 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Greenmount, Gwynn | Mar 19 1927 |
| 20 UNDERTAKER | ADDRESS |
| J. W. Cook | 502 E North Ave |

Cor.—12-9-25—A Co.—200 Bks.

E 20279

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 ✓ E 20279

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2627 E. Chase St. 8-12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis R. Loyn

(a) RESIDENCE NO. 2627 E. Chase St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| male | white | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mattie Loyn

6 DATE OF BIRTH (month, day, and year) May 29/1874

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 52 | 9 | 18 17 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman- Highway

(b) General nature of industry, business, or establishment in which employed (or employer) Engineer Dept.

(c) Name of employer Balto., City, Md.

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs. Mattie Loyn

(Address) 2627 E. Chase St

MAR 18 1927 HARRY WOODS, M. D.

Per Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 Mar 16/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocarditis

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) "Reported" Angina Pectoris

(duration) .....yrs. .....mos. .....ds.

(Signed) J. M. Call M. D.

(Coroner)

3/17/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Date of Burial Mar 19 1927

20 UNDERTAKER William Cook ADDRESS 502 E North Ave

Spec.—1-10-21—M&T—1500 Blks.

20280

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 20280

1-PLACE OF DEATH Maryland General Hosp. 11-24

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Bowers.

(a) RESIDENCE NO. Reisterstown, Md. ST., ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 10 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ——

6 DATE OF BIRTH (month, day, and year) Aug 12, 1902

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 24 | 7 | 5 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Factory worker.

(b) General nature of industry, business, or establishment in which employed (or employer) At Oakland Mills

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Reisterstown, Md.

PARENTS

10 NAME OF FATHER George W. Bowers.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Reisterstown, Md.

12 MAIDEN NAME OF MOTHER Mary E. R. Vaughn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Reisterstown Md.

14 Informant Hospital Record.

(Address)

15 Filed MAR 8 1927 19 C. HAMPTON JONES, M. D. Registrar

Per RR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 1927

17 I HEREBY CERTIFY, That I attended deceased from March 8, 1927, to March 17, 1927, that I last saw h[illegible] alive on March 17, 1927, and that death occurred, on the date stated above, at 2:45 P m.

The CAUSE OF DEATH* was as follows:

Stricture of rectum - due to growth - pernicious malignancy.

(duration) ..... yrs. ? mos ..... ds.

CONTRIBUTORY (Secondary) Toxemia.

(duration) ..... yrs. 2? mos. ..... ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Clinical.

(Signed) Jno. Young Davis M. D.

, 19 (Address) Md. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Wards Chapel Cemetery | Mar 20 1927 |
| UNDERTAKER | ADDRESS |
| J. F. Ebaugh & Sons | Reisterstown Md |

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20281

CERTIFICATE OF DEATH. 38

E 20281

REGISTERED NO.

1-PLACE OF DEATH Balto City Hospitals

City of BALTIMORE: (No. Balto Md 25-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hester Thomas

(a) RESIDENCE NO. 107 Leadenhall St Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 Color or Race Black

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year) unknown.

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| 49 | | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Factwork

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Balto City Hospitals

(Address) Balto Md.

15 Filed 3 8 1927, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14-27

17 I HEREBY CERTIFY, That I attended deceased from 2-7-, 1926, to 3-14, 1927, that I last saw her alive on 3-13, 1927, and that death occurred, on the date stated above, at 12.30 A. m.

The CAUSE OF DEATH* was as follows: General Paralysis of Insane

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Luetic Infection

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Findings

(Signed) Harry H. Glover M. D.

3/14/1927 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Ct Date of Burial March 18 1927

20 UNDERTAKER A. L. Brown and Son ADDRESS 108 W. Monument

Spec.—12-9-25—A Co.—200 Bks.

E 20282

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20282

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St., 5-6 Ward)

REGISTERED NO. 74-091

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John R. Mason

(a) RESIDENCE NO. 200 Colvin St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Negro | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) August 17 1854

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| 67 | 66 | 6 | 29 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labour

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 BALTIMORE CITY HOSPITALS

Informant

(Address) [redacted]

C. HAMPSON JONES, M. D.

15 Filed ... 19 ... Per ... Registrar

T 8 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16 1927

17

I HEREBY CERTIFY, That I attended deceased from August 23, 1925, to March 16, 1927, that I last saw h. in alive on March 15, 1927, and that death occurred, on the date stated above, at 6.30 H m.

The CAUSE OF DEATH* was as follows:

Cerebral Sclerosis

Hypertension

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death!

Did an operation precede death! no Date of

Was there an autopsy! no

What test confirmed diagnosis! laboratory

(Signed) G. Hooper Linthicum, M. D.

March 19 27 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cemtry — Date of Burial 3/19 1927

20 UNDERTAKER Mrs Geo W Hooper — ADDRESS 406 W Conway St

Cor.—12-9-25—A Co.—200 Bks. THE MORGUE.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20283 — CERTIFICATE OF DEATH. — E 20283

181-00!

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital St., 6-9 Ward)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alonzo F. [illegible] Hupp

(a) RESIDENCE NO. 306 N. Broadway St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lucinda Hupp

6 DATE OF BIRTH (month, day, and year) unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | About 47 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Arundel Corp.

(c) Name of employer Sand & Gravel

9 BIRTHPLACE (city or town) _____

(State or country) Orville Ohio.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country)

14 Informant Hospital Records & Wife

(Address) _____

15 Filed 1927 17 _____

C. HAMPSON JONES, M. D.

Per RKT Registrar

THE MORGUE.

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Monoxide Gas Poisoning Accidental from gas range on Mar 3/27

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Alconolism

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. [illegible] M. D.

(Coroner)

3/14/27 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the state.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cemetery Date of Burial March 9, 1927

20 UNDERTAKER Richard F. Curley ADDRESS 1808 N. Bway

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20284

## CERTIFICATE OF DEATH.

74-001

E 20284

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1300 Myrtle ST. 17-2C (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Siegel

(a) RESIDENCE NO. 1300 Myrtle ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 27 yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | W | married |

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Isaac Siegel

DATE OF BIRTH (month, day, and year) unknown

| AGE | Years | Months | Days | If LESS than 1 day, ....hrs or....min. |
|---|---|---|---|---|
| | 68 | — | — | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Abraham Simons

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sarah Simons

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

Informant Jacob Siegel

(Address) 1300 Myrtle Ave

C. HARRISON ELLIS, M. D.

Filed MAR 18 1927 [illegible] Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Feby 18th, 1927, to March 18th, 1927, that I last saw her alive on March 17th, 1927 and that death occurred, on the date stated above, at 10 a. m

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) — yrs. one mos — ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Stuart F. Rieman, M. D.

, 19 (Address) 6 East Biddle St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rodeph Shalom Road

DATE OF BURIAL 3.5 19 27

20 UNDERTAKER Jacob Levi

ADDRESS 1451 E Biddle

Spec.-7-17-26—A Co.—200 Bks.

20285

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

90 E 20285

1-PLACE OF DEATH University Hospital REGISTERED NO. 27441

City of BALTIMORE: (No. ..... St., ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Allen Pierce McKay

(a) RESIDENCE NO. 424 Hazelwood Ave St. Roslyn Ward .

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. ..... mos. ..... ds. How long in U. S. If of foreign birth? ..... yrs. ..... mos. ..... ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec 29, 1904

7 AGE — Years: 22 — Months: 2 — Days: 16 — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Dental Student

(b) General nature of industry, business, or establishment in which employed (or employer): ddo

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md

PARENTS

10 NAME OF FATHER: Henry V.

11 BIRTHPLACE OF FATHER (City or town): Md

(State or country)

12 MAIDEN NAME OF MOTHER: Helen Murphy

13 BIRTHPLACE OF MOTHER (city or town): West Indies

(State or country)

14 Informant: Hospital Records

(Address)

Filed MAR 18 1927 E. HAMBLETON JONES, M. D. Registrar

per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/15/27 19

17 I HEREBY CERTIFY, That I attended deceased from 3/5/27, 19..., to 3/15/27, 19...,

that I last saw him alive on 3/15/27, 19...,

and that death occurred, on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH* was as follows:

Myocardial Failure

(duration) ..... yrs. ..... mos. 2 da.

CONTRIBUTORY (Secondary) Auricular Fibrillation, Acute Endocarditis

(duration) ..... yrs. ..... mos. 10 da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. E. Woodhead, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cemetery — Date of Burial: Mar 18 27

(UNDERTAKER) Henry H. Wurzbach — ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

E 20286 HEALTH DEPARTMENT—CITY OF BALTIMORE E 20286

1 / 001

16

# CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Woman's Hospital 15-61 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Knipfs.

Parent's

(a) RESIDENCE NO. 2707 Allendale Rd ~~St~~. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 18, 1927

| 7 AGE | Years | Months | Days | If LESS than 1 day, 3 hrs. or 48 min. |
|---|---|---|---|---|
| | | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore.
(State or country)

PARENTS

10 NAME OF FATHER John C Knipfs.

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Marian Guthrie.

13 BIRTHPLACE OF MOTHER (city or town) Roanoke, Va.
(State or country)

14 Informant John C Knipfs
(Address) 2707 Allendale Rd

15 Filed MAR 18 1927 C. HAMPTON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 18 1927

17

I HEREBY CERTIFY, That I attended deceased from March 18, 1927, to March 18, 1927,

that I last saw him alive on March 18, 1927,

and that death occurred, on the date stated above, at 6:20 A m.

The CAUSE OF DEATH* was as follows:

Prematurity.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY .....
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) H. H. Kirk, M. D.

, 19 (Address) Woman's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge

DATE OF BURIAL Mar 18 1927

20 UNDERTAKER Wm J. Tuckwell & Son

ADDRESS N. Y. Pa

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20287

E 20287

## CERTIFICATE OF DEATH

6-68 74-001

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 2711 Winchester St. | 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. H. Deady.

(a) RESIDENCE NO. 2711 Winchester St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Laura M. Deady.

6 DATE OF BIRTH (month, day, and year) August 30, 1879

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 47 | 7 | 14 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Telegraph Operator

(b) General nature of industry, business, or establishment in which employed (or employer) R.R.

(c) Name of employer Penna R. R.

9 BIRTHPLACE (city or town)..... (State or country) Md.

PARENTS

10 NAME OF FATHER John L. Deady

11 BIRTHPLACE OF FATHER (city or town)..... (State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Jones

13 BIRTHPLACE OF MOTHER (city or town)..... (State or country) Md.

14 Informant Laura M. Deady (Address) 2711 Winchester St.

15 Filed ..... 19.. A.M. ..... H. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) no history

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D.

(Coroner)

19 27 (Address) 2802 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. Date of Burial March 19 1927

20 UNDERTAKER Mrs. Albert E. Fuller ADDRESS 4506 Harford ave.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20288

## CERTIFICATE OF DEATH.

11-24 90

E 20288

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1301 Linden ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan W. Allen

(a) RESIDENCE NO. 1301 Linden ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 14, 1851

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| 76 | 76 | — | 3 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER Robert Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Ferguson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

PARENTS

14 Informant Katharine Allen Pennington

(Address) 1301 Linden avenue

15 Filed MAR 18 1927 H. HARRISON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-17 1927.

17 I HEREBY CERTIFY, That I attended deceased from 3-13, 1927, to 3-17, 1927, that I last saw h[illegible] alive on 3-17, 1927, and that death occurred, on the date stated above, at 4 45 8 m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis

Hemiplegia

Myocarditis.

(duration) yrs. 2 mos 2 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no What test confirmed diagnosis? Clinical findings

(Signed) M D Lord, M. D.

19 (Address) 140 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL Mar 19 1927

20 UNDERTAKER J. W. Jenkins Son Co.

ADDRESS Cleveland and McCulloh

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20289

## CERTIFICATE OF DEATH.

90 E 20289

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2310 E Preston ST. 8-16 WARD)

2-FULL NAME Charles E. Reilly

(a) RESIDENCE NO. 2310 E. Preston St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | M |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Irene B Reilly

6 DATE OF BIRTH (month, day, and year) June 15 67

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 59 | 9 | 1 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Proprietor

9 BIRTHPLACE (city or town) Balto. Md. (State or country)

PARENTS

10 NAME OF FATHER Robert Reilly

11 BIRTHPLACE OF FATHER (city or town) Balto. Md (State or country)

12 MAIDEN NAME OF MOTHER Meyer

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md (State or country)

14 Informant Irene B Reilly

(Address) 2310 E Preston

15 Filed 8-1927, 19 C. HARRISON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16 19 27

17 I HEREBY CERTIFY, That I attended deceased from February 14 19 27 to March 16 19 27.

that I last saw h alive on March 16 19 27

and that death occurred, on the date stated above, at 11.30P m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation (Cholera compensation)

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemmorhage

(duration) yrs. mos. 0 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis Physical examination

(Signed) P E Reilly, M. D.

Mar 17 19 27 (Address) 811 E Hunt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Mar 19 1927

20 UNDERTAKER W M Rockson

ADDRESS 2238 N Smith

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 20290 — 129

1-PLACE OF DEATH — REGISTERED NO. E 20290

City of BALTIMORE: (No. 3036 Edmondson Ave. W. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Vogelsang

(a) RESIDENCE NO. 3036 Edmondson Ave. W. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louis Vogelsang

6 DATE OF BIRTH (month, day, and year): Mar. 21, 1854

7 AGE — Years: 67 — Months: 11 — Days: 6 24 — IF LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: George H. Hill

11 BIRTHPLACE OF FATHER (City or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Jane Stephens

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs Emma Smith

(Address): 3036 Edmondson Ave

15 Filed MAR 18 1927

C. HARTON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: March 15 - 1927

17 I HEREBY CERTIFY, That I attended deceased from March 10, 19 27, to March 15, 19 27,

that I last saw h. alive on March 15, 19 27,

and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Brights Disease

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary): Uremia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted: —

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. Tilden M. D.

3/17 19 27 (Address) 1779 Williams

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Cemetery — Date of Burial: Mar. 18 1927

UNDERTAKER: Margaret S. Flynn — ADDRESS: 1422 Light St.

Spec.—7-17-26—A Co.—200 Bks.

E 20291

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20291

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. 49

City of BALTIMORE: (No. Earl Court Apts St. 12-19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME N. Virginia Spalding

(a) RESIDENCE NO. St Paul & Preston St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 14/1867

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 59 | 5 | 3 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER Carey McClelland

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER Mary Green

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Md

14 Informant Miss Helen A. Spalding

(Address) Earl Court Apartments

Filed 8 1927 C. HAMPSON JONES, M. D.

Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Mar. 17, 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 8, 1927, to Mar 19, 1927, that I last saw her alive on Mar 17, 1927, and that death occurred, on the date stated above, at 6:45 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of bladder (Primary)

(duration) about 6 mos. ds.

CONTRIBUTORY None (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? at home.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? biopsy

(Signed) P. M. Hincke M. D.

, 19 (Address) 1107 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge

Date of Burial Mar 19 1927

20 UNDERTAKER George J. Smith

ADDRESS 153 Hollins

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20292 E 20292

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hospital (St.) 7542 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Simon B. Phifer

(a) RESIDENCE No. 1010 Hamlin St. N.E. (St.) Washington (Ward)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M. | W. | Married |

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Belle V. Phifer.

DATE OF BIRTH (month, day, and year) 1852

| AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| 75 | | | | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Ohio - Knox Co

10 NAME OF FATHER Geo A. Phifer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Louisa Phifer.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

Informant Geo. Phifer

(Address) 1010 Hamlin St N. E. Washington D.C.

Filed 1927 C. HARRISON JONES, M. D. Registrar

By Asst

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 19, 1927

17 I HEREBY CERTIFY, That I attended deceased from 3-14, 1927, to 3-18, 1927, that I last saw h[illegible] alive on 3-18, 1927 and that death occurred, on the date stated above, at 7:35 p. m.

The CAUSE OF DEATH* was as follows:

BRONCHO-PNEUMONIA

FOLLOWING RESECTION OF MANDIBLE FOR CARCINOMA

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) SENILITY -

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? YES Date of 3-15-27

Was there an autopsy? NO

What test confirmed diagnosis? PHYSICAL EXAM.

(Signed) WPC TO Brown M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Washington D.C. | 3/18, 1927 |

20 UNDERTAKER Herbert B. Norris

ADDRESS 924-N.J. Ave. N.W. Wash., D.C.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20293

## CERTIFICATE OF DEATH.

171 E 20293

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hosp St. 10-15 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stephen Moby.

(a) RESIDENCE NO. City Jail St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years: 41 — Months — Days — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 027

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER Police Bill

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant

(Address)

8 1927 C. HAMPSON JONES, M. D.

Per Registrar

THE MORGUE 1175

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 2 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows)

Suicide by Cutting throat with razor.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) M. D.

(Coroner)

Mar 7 1927 (Address) 1644 Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

20 UNDERTAKER — ADDRESS

UNIVERSITY OF MARYLAND MAR 18 1927
Commissioner Health

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20294

E 20294

## CERTIFICATE OF DEATH.

66

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 48 Market Space St. 4-6 Ward)

2-FULL NAME Wm. Noonan

(a) RESIDENCE NO. 48 Market Space St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | white | Married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 57 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shipping

(b) General nature of industry, business, or establishment in which employed (or employer) Shipping

(c) Name of employer Shipping

9 BIRTHPLACE (City or town) Ireland

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Interment

(Address)

15 Filed 1927 C. HARRISON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest

(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accident

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

(Coroner)

March 17, 1927 (Address) 1634 Bank

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ..... mos., ..... ds. In the State ..... yrs., ..... mos., ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial 19

20 UNDERTAKER

ADDRESS

UNIVERSITY OF MARYLAND
Commissioner Health
MAR 5 1927

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20295

## CERTIFICATE OF DEATH.

201 E 20295

1-PLACE OF DEATH

City of BALTIMORE: (No. Marcy Hosp (St. 4-7 Ward)

2-FULL NAME O'Brien — (Lutkman)

(a) RESIDENCE NO. — St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | white | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 30 | 11 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant

(Address)

15 Filed 19

Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract Skull
a cerebellum
Cerebellum
Traumatic Shock

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) M. D.

(Coroner)

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

UNIVERSITY OF MARYLAND
C. HAMPSON JONES, M. D.
Registrar
Cemetery Books

Spec.—1-12-23—M&T—500 Bks.

(Kiraly)

E 20296

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-081

E 20296

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hospital (St.) 6-10 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Jenee Kiraly (Kraly)

(a) RESIDENCE NO. 29 North Clover ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 58 | | | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER ✓

11 BIRTHPLACE OF FATHER (city or town) (State or country) ✓

12 MAIDEN NAME OF MOTHER ✓

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant Mrs. M. Wilkins

(Address) 26 N. Clover St.

Filed 3-19-1927, 19 C. HAMILTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18 1927

17 I HEREBY CERTIFY, That I attended deceased from 3/17/27, 1927, to 3/18/27, 19

that I last saw h alive on 3.00 am 3/18/27.

and that death occurred, on the date stated above, at 3.00 am.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia
& acute nephritis with
cardiac failure as the terminal
cause (duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No, Date of —

Was there an autopsy? ✓

What test confirmed diagnosis? Physical Exam.

(Signed) A. J. Kubapp, M. D.

3-18, 1927 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Disinterred and buried in mount Carmel Ca

DATE OF BURIAL: March 18 1927

20 UNDERTAKER: Mrs. E. Mittal Veal

ADDRESS: 1304 Jefferson St

UNIVERSITY OF MARYLAND

Spec.—1-12-23—M&T—500 Bks.

E 20297

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

100 E 20297

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) St. Agnes Hospital. St. 4-W (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lewis Albaugh.

(a) RESIDENCE NO. 721 N Lexington St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word)

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| 69 | | | | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Maryland

10 NAME OF FATHER:

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant: Lewis Albaugh.

(Address) 721 N. Lexington St. City

Filed , 19

C. HARRISON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-17- 1927

17 I HEREBY CERTIFY, That I attended deceased from 3-11- , 1927, to 3-17 , 1927,

that I last saw him alive on 3-17-27 , 19 P. M.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Hypertrophy & Prostate

and retention of Urine

(duration) 7 yrs. mos ds.

CONTRIBUTORY (Secondary) Cystitis - Ureteritis and a Terminal Pneumonia (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? ✓ (Agnes)

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical.

(Signed) A. J. Knapp, M. D.

3-18, 1927 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

MAR 19 1927

DEPARTMENT OF HEALTH

Commissioner Health

Spec.—12-9-25—A Co.—200 Bks.

E 20298

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 20298

REGISTERED NO. 1427 31

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. [illegible] Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cora Lee Smith

(a) RESIDENCE NO. 225 N. Parrish Alley St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Colored | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1909

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 18 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER Harry Smith

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Parthemia Perger

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant Hospital Records

(Address)

15 Filed....., 19.....

Registrar

1180

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from March 8 19 27, to March 13 19 27,

that I last saw her alive on March 13, 19 27,

and that death occurred, on the date stated above, at 11.30a m.

The CAUSE OF DEATH* was as follows:

a. Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) W. E. Gattens, M. D.

3-14-27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND Date of Burial MAR 18 1927 19

20 UNDERTAKER C. HAMPSON JONES, M. D. ADDRESS Health Officer

Per RRA

Spec.—1-12-23—M&T—500 Bks.

E 20299 HEALTH DEPARTMENT—CITY OF BALTIMORE E 20299

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1508 John St.) Bon Secours Hosp. (WARD) 14 — REGISTERED NO. 20101

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriett Julia Bennett

(a) RESIDENCE No. 1508 John ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX F. | 4 COLOR OR RACE W | 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2 1850

7 AGE Years 77 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER John Bennet

11 BIRTHPLACE OF FATHER (city or town) (State or country) City

12 MAIDEN NAME OF MOTHER Jane Adams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) City

4 Informant (Address) Mrs. Kemp 1601 Park Ave.

5 MAR 3 1927 C. HAMPSON JONES, M. D. Registrar

Per

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 17th 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar. 15, 1927, to Mar. 17, 1927, that I last saw her alive on Mar 17, 1927, and that death occurred, on the date stated above, at 10 30 m.

The CAUSE OF DEATH* was as follows:

③ Chronic Myocarditis

② Arterio sclerosis

① Lobar Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) — yrs. — mos. 7 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) George O. Eaton, M. D.

, 19 (Address) Bon Secours Hosp'l.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorbathedralben | DATE OF BURIAL 3/19/1927

20 UNDERTAKER J. A. Moran | ADDRESS 700 E. Belvedere

Spec.—8-24-14—M. & T.—2000 Bks.

(Werther)

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20300 E 20300

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3021 E. Monument St. 6-11 (WARD)) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Carroll Werther

(Residence in Baltimore: No. 3021 E. Monument St. 49 yrs., mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, July (Month) 7th (Day), 1898 (Year)

7-AGE, 28 yrs. 8 mos. 11 ds.

If LESS than 1 day, ....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Machinist
(b) General nature of industry, business, or establishment in which employed (or employer): Ord

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Theodore G. Werther

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Lulu Peterson

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Bessie M. Werther

(Address) Glen Arm Md.

15- C. HAMPSON JONES, M. D.

Filed 1927, Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar 18, 1927. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar 13 1927, to Mar 18th 1927, that I saw h[er] alive on Mar 18 1927, and that death occurred, on the date stated above, at 11.45 a. m.

The CAUSE OF DEATH* was as follows: Carcinoma of Liver

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Stomach

(Duration) 8 yrs. mos. ds.

(Signed) William Daw M. D.

3/18, 1927 (Address) 1901 E. Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Parkwood Cemetery — DATE OF BURIAL, Mch 21 1927

20-UNDERTAKER Clarence E. Luther — ADDRESS Fork Md

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20301

E 20301

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 702 N. Stricker St. (ST.) 16-22 (WARD)

REGISTERED NO. 101001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Lewis

(a) RESIDENCE NO. 702 N. Stricker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jas. Lewis

6 DATE OF BIRTH (month, day, and year): 1872

7 AGE: Years 55; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country): Spottsylvania Court House Va.

PARENTS

10 NAME OF FATHER: John Turner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Kirkstown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Louise Nash, Daughter (Address) 322 N. Stricker St

15 FILED 8 1927 C. HAMPSON JONES, M. D. Registrar. Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3-16-1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 25 —, 1927, to 3-16-, 1927, that I last saw h[illegible] alive on 3-16-, 1927, and that death occurred, on the date stated above, at 945 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary): Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) George C Rose, M. D.

, 19 (Address) 1816 Mount St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem

DATE OF BURIAL: March 19 27

20 UNDERTAKER: Daniel Easton

ADDRESS: Laurel

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20302

## CERTIFICATE OF DEATH

129 E 20302

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. University Hosp St. 14-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Jackson

(a) RESIDENCE NO. 1710 W Fayette St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Femal

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE: Years 55 Months Days IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto City

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Mrs Jackson

(Address) 1710 W Fayette St

15 Filed C. HAMPSON JONES, M. D. Registrar

By April

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 17 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar. 14, 1927 to Mar 17, 1927, that I last saw h[illegible] alive on Mar 17 PM, 1927, and that death occurred, on the date stated above, at 6 PM m.

The CAUSE OF DEATH* was as follows:

Cardiovascular renal disease probably Infections in organs

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Ac. Cardiac failure

(duration) yrs. mos. 4 ds.

18 Where was disease contracted

If not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) [illegible], M. D.

, 19 (Address) University Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — Date of Burial: March 18/27

20 UNDERTAKER: Daniel Carter — ADDRESS: Balto

8 1927

Spec.—12-9-25—A Co.—200 Bks.

20-290 E 20303

# HEALTH DEPARTMENT—CITY OF BALTIMORE

44 E 20303

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL, S. 14-20 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Blake

(a) RESIDENCE NO. 1812 Ethel St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of: Sarah

6 DATE OF BIRTH (month, day, and year): 1877

7 AGE: Years 50; Months; Days; If LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cemetery Keeper

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town): Usa

(State or country)

PARENTS

10 NAME OF FATHER: Joseph Blake

11 BIRTHPLACE OF FATHER (city or town): Md

(State or country)

12 MAIDEN NAME OF MOTHER: Millie Blake

13 BIRTHPLACE OF MOTHER (city or town): Md

(State or country)

14 Informant: Record

(Address) JOHNS HOPKINS HOSPITAL

15 1927 C. HAMPSON JONES, M. D. Registrar

Apr 11

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 17 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb 16, 1927, to March 17, 1927, that I last saw him alive on March 17, 1927, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach.

1 week

(duration) 1 yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

2 weeks (duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? yes Date of 2-24-27

Was there an autopsy?

What test confirmed diagnosis? operation.

(Signed) Lawrence R Smith, M. D.

. 19 (Address) Johns Hopkins Hospital. Balto. Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — Date of Burial March 19/27

20 UNDERTAKER: David Easton — ADDRESS Balto

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20304

101-021

E 20304

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St. 17-26 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Walters

(a) RESIDENCE NO. 700 W. Mulberry St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Negro | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edna Walters

6 DATE OF BIRTH (month, day, and year) 1899

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 28 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labour

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) North Carolina

PARENTS

10 NAME OF FATHER Alex Walters

11 BIRTHPLACE OF FATHER (city or town)

(State or country) North Carolina

12 MAIDEN NAME OF MOTHER Sarah —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) North Carolina

14 Informant BALTIMORE CITY HOSPITALS

(Address) Records

15 Filed [illegible] 19 1927 HARPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 1927

17

I HEREBY CERTIFY, That I attended deceased from March 12, 1927, to March 17, 1927, that I last saw him alive on March 17, 1927, and that death occurred, on the date stated above, at 8.40 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. ? ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) ..... yrs. ..... mos. ? ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Pathologically

(Signed) R. Hooper Smith M. D.

19 [illegible] (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Date of Burial March 18 1927

20 UNDERTAKER Daniel Easton ADDRESS 916 Eare

Spec.—12-9-25—A Co.—200 Bks.

E 20305

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

93 E 20305

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospital St., 14-20 Ward)

2-FULL NAME Wm W Jones

(a) RESIDENCE NO. 1406 Butler St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1883

7 AGE: Years 44 | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Md

(State or country) Balto City

10 NAME OF FATHER Chas A Jones

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Md

12 MAIDEN NAME OF MOTHER Georgianna ?

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Md

PARENTS

14 Informant Lucial Jones

(Address) 1406 Butler St

15 Filed ..... 19 MAR 18 1927 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17, 1927

17 I HEREBY CERTIFY, That I attended deceased from 2-28, 1927, to 3-17, 1927, that I last saw him alive on 3-17, 1927, and that death occurred, on the date stated above, at 11:45 m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

Strangulated

(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary) Pneumonia

Septicemia (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of 2-28-27

Was there an autopsy? No

What test confirmed diagnosis? Laboratory Findings

(Signed) Burns, M. D.

, 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem Date of Burial March 19 1927

20 UNDERTAKER: Daniel Eaton ADDRESS 846 Eutaw

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20306 E 20306

## CERTIFICATE OF DEATH.

31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 806 N Bond ST. 7-13 WARD)

2-FULL NAME Wm H Clark

(a) RESIDENCE NO. 806 N. Bond ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | C | Married |

5a If married, widowed, or divorced HUSBAND of ~~WIFE~~ Sarah L Clark.

6 DATE OF BIRTH (month, day, and year) Nov. 28 1853

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 73 | 3 | 18 | — |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Skill Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Post office.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cambridge Md

PARENTS

10 NAME OF FATHER Abraham Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Sarah L Clark wife (Address) 806 E Street

15 Filed 1 8 1927, 19 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 19 28 to March 16 19 27 that I last saw him alive on March 16 19 27 and that death occurred, on the date stated above, at 9.20 P.m.

The CAUSE OF DEATH* was as follows:

Lung Abscess 6 wks

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R J Cushing, M. D.

3/16, 19 27 (Address) 1424 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cambridge Md DATE OF BURIAL March 19 27

20 UNDERTAKER Heinl Easton ADDRESS Cambridge Md

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20307

CERTIFICATE OF DEATH

74-001

E 20307

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 2200 Garrison Avenue St. 15-61 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ann K. Spangler

(a) RESIDENCE NO. 2200 Garrison Avenue St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 7, 1863

7 AGE: Years 63 Months 7 8 11 Days 22

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): York

(State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Jacob Spangler

11 BIRTHPLACE OF FATHER (City or town) York

(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Harriett Odenwald

13 BIRTHPLACE OF MOTHER (city or town) York

(State or country) Pennsylvania

14 Informant: Miss Elizabeth H. Spangler

(Address) 2200 Garrison Avenue

15 Filed 1927 C. HARRISON JONES, M. D. Registrar

Per RKB

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: March 18, 1927

17 I HEREBY CERTIFY, That I attended deceased from March 14, 1927, to March 18, 1927, that I last saw her alive on March 17, 1927, and that death occurred, on the date stated above, at 10 a.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis - high blood pressure - cerebral hemorrhage and paralysis

(duration) 2 yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage & paralysis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Physical What test confirmed diagnosis?

(Signed) W. S. Willett M. D.

(Address) 2220 Garrison Avenue

3-18-27

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: York, Pennsylvania

Date of Burial: Mar. 21 1927

20 UNDERTAKER: Joseph H. Cook

ADDRESS 7003 Belair Rd

Spec.-7-17-26—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20308

## CERTIFICATE OF DEATH

124 E·20308

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 3219 Carlisle Avenue St. 15-61 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah H. Anderson

(a) RESIDENCE NO. 3219 Carlisle Avenue St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widowed |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of William J. Anderson

6 DATE OF BIRTH (month, day, and year)
Feb. 28, 1841

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 86 | xxx | 19 17 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Somerset County, Md.

PARENTS

10 NAME OF FATHER Nathan J. Langford

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliza Wilson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Mrs. George V. Green

(Address) 3219 Carlisle Avenue

15 8 1927 C. HARRISON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

March 17, 1927

17 I HEREBY CERTIFY, That I attended deceased from March 13th, 1927, to March 17th, 1927,

that I last saw h. er alive on March 16th, 1927,

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
Arteriosclerosis.

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. 4 ds.

18 Where was disease contracted

if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Necropsy.

(Signed) Stuart F. Stineman, M. D.

3-17-1927 (Address) 6 East Biddle Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Princess Anne, Maryland | Mar. 20 1927 |
| 20 UNDERTAKER Joseph D. Cook | ADDRESS 1003 W. Balto St. |

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20309

## CERTIFICATE OF DEATH.

11-001

E 20309

1-PLACE OF DEATH

City of BALTIMORE: (No. 3310 Foster Ave 26-2 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Dressler.

(a) RESIDENCE NO. 3310 Foster Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 26-1922

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 4 | 3 | 21 19 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER John Dressler

11 BIRTHPLACE OF FATHER (city or town) Italy

(State or country) Italy

12 MAIDEN NAME OF MOTHER Mary Ebner

13 BIRTHPLACE OF MOTHER (city or town) Germany

(State or country)

14 Informant John Dressler (Father)

(Address) 3310 Foster Ave.

15 Filed 1927 C. HARRISON JONES, Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 1927

17 I HEREBY CERTIFY, That I attended deceased from March 6, 1927, to March 19, 1927, that I last saw h.. alive on March 19, 1927, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows)

Influenza

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Pneumonia (Lobar)

(duration) yrs. mos. 5 ds.

18 Where was disease contracted

If not at place of death)

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Eugene Lockard G. M. D.

, 19 (Address) 806 S. 32 St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cem. Date of Burial March 19 1927

20 UNDERTAKER: Lilly & Zeiler ADDRESS 403 S. Wolfe St.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20310

## CERTIFICATE OF DEATH.

74-001 E 20310

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME Instead of street and number.)

I-PLACE OF DEATH

City of BALTIMORE: (No. 2501 Jefferson St. St., 6-10 Ward)

2-FULL NAME Rose Pellicot

(a) RESIDENCE NO. 2501 Jefferson St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow. |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Pellicot.

6 DATE OF BIRTH (month, day, and year) June 15-1864

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 62 | 9 | 2 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of indnstry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER Caspar Kentner

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ger.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany.

14 Informant Frank Pellicot

(Address) 2501 Jefferson St.

Filed 3-18 1927 C. HARRISON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 6 1927, to Mar 16, 1927, that I last saw h... alive on Mar 16, 1927, and that death occurred, on the date stated above, at 7.50 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY Arteriosclerosis

(Secondary)

(duration) 2 yrs. mos. ds.

Is Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Edith J Green, M. D.

3-18, 1927 (Address) 120 Argyle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Emily Cem. March 20 1927

20 UNDERTAKER ADDRESS

Lilly & Zeiler 403 S. wolfe st.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20311

## CERTIFICATE OF DEATH

3 1 E 20311

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 102 S Wolfe St St. 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Wojciechowski

(a) RESIDENCE NO. 102 S Wolfe St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? 33 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Helen Wojciechowski

6 DATE OF BIRTH (month, day, and year)
April 22 1880

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 46 | 11 | 10 24 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 040

(b) General nature of industry, business, or establishment in which employed (or employer) Labor

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Poland

PARENTS

10 NAME OF FATHER Ignacy Wojciechowski

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Elezebeth Wojciechowski

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Helen Wojciechowski

(Address) 102 S Wolfe St

8 1927 C. HAMPSON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

March 16 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 11 1927 to March 16 1927

that I last saw him alive on March 15 1927

and that death occurred, on the date stated above, at 945 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary T. B.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous Enteritis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted

if not at place of death? 532 S Ann St.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam.

(Signed) March 18 1927 A. F. Reis, M. D.

(Address) 24 S. Bury

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Holy Rosary cem — Date of Burial March 21 1927

20 UNDERTAKER — John McWeber — ADDRESS 1803 Bank St

Very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

200936

# HEALTH DEPARTMENT—CITY OF BALTIMORE

38 E 20312

E 20312

## CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSP. St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Carr

(a) RESIDENCE NO. 917 McCulloh St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Black

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Estelle

6 DATE OF BIRTH (month, day, and year): ? 1885

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 42 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clergyman

(b) General nature of industry, business, or establishment in which employed (or employer): 018

(c) Name of employer

9 BIRTHPLACE (city or town): Ala —

(State or country)

PARENTS

10 NAME OF FATHER: ?

11 BIRTHPLACE OF FATHER (city or town): ?

(State or country): Ala

12 MAIDEN NAME OF MOTHER: Lucy ?

13 BIRTHPLACE OF MOTHER (city or town): ?

(State or country): Ala

14 Informant: Records

(Address): JOHNS HOPKINS HOSP.

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: Mar 17-1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 8, 1927, to Mar 17, 1927, that I last saw him alive on Mar 17, 1927, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows: Syphilitic aortitis, aortic insufficiency, myocardial insufficiency, ulcerative bacterial endocarditis.

(duration) 1+ yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) C. Lovett Andrus, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: W. M. Zulauf — Date of Burial 3/20/1927

20 UNDERTAKER: Mrs. Ga. H. Kelland — ADDRESS 1631 Druid Hill

Spec.—1-12-23—M&T—500 Blks.

E 20313

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20313

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore Md

CITY OF BALTIMORE: (No. 311 N. Greene St. 10th WARD)

REGISTERED NO. 74

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Phillip Zanti

(a) RESIDENCE NO. ~~311~~ 205 Lansdowne Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine Zanti

6 DATE OF BIRTH (month, day, and year) May 17-1866

7 AGE

| Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|
| 61 | 10 | 1 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Domenick Zanti

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Helen Amary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Angelo Zanti

(Address) 152 W Fayette St

15 Filed 8 1927 19

C. HAMPSON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 17, 1927, to Mar 18, 1927, that I last saw h. alive on Mar 18, 1927 and that death occurred, on the date stated above, at 4:30 pm

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. Hampson Jones, M. D.

, 19 (Address) 94 311 Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudendale Cem

DATE OF BURIAL Mar 21 1927

20 UNDERTAKER W M Rouston

ADDRESS 2238 N Monroe

Spec.–7-17-26—A Co.—200 Bks.

Dr Gorsuch 117 W Lanvale St

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20314

E·20314

74-001

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of BALTIMORE: (No.) 525 N Monroe St. 20-27 Ward

2-FULL NAME Augusta Jones

(a) RESIDENCE NO. 525 N Monroe St. Ward

(Usual place of abode)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| F | N. | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE 68 Years 67 Months Days IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer St Mortus Church

9 BIRTHPLACE (city or town)

(State or country) Balt Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (City or town)

(State or country) Unknown

14 Informant Geo A Hoos

(Address) 222 E 39th St

15 Filed MAR 8 1927 C. H. [illegible] Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 1927

17 I HEREBY CERTIFY, That I attended deceased from March 15 1927 to March 17 1927

that I last saw her alive on March 16 1927

and that death occurred, on the date stated above, at 9:41 m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) yrs. a few hours mos. ds.

CONTRIBUTORY (Secondary) don't know

(duration) yrs. mos. ds.

18 Where was disease contracted Home

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

19 (Address) 117 W Lanvale St

3-8-27

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem Date of Burial March 19 27

20 UNDERTAKER W M Cook ADDRESS 307 E Lafayette

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20315

## CERTIFICATE OF DEATH

11-901 E·20315

1-PLACE OF DEATH

City of BALTIMORE: (No. 413 West Ostend St. 1-3 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Stokes

(a) RESIDENCE NO. 413 West Ostend St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 24/1910

7 AGE: Years 16 Months 9 Days 22 IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Dyer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Balto Navy Co

9 BIRTHPLACE (city or town)

(State or country): Balto Md

PARENTS

10 NAME OF FATHER: Thos H. Stokes

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Bertha C Sutton

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: Bertha C Stokes

(Address): 413 West Ostend

15 Filed 3 1927 C. HAMPSON JONES, M. D. Registrar

Per ARH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/16 1927

17 I HEREBY CERTIFY, That I attended deceased from 3/7, 1927, to 3/16, 1927.

that I last saw h- alive on 3/16, 1927.

and that death occurred, on the date stated above, at 1015 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Bronchial Pneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) J. E. Emrich M. D.

(Address) 910 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — Date of Burial 3/19 1927

20 UNDERTAKER: Wm Cook — ADDRESS 5 N E Wood

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

20316 E 20316

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 300 E. Fort Ave (St.) 24-33 (WARD) 11

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John George

(a) RESIDENCE NO. 300 E. Fort Ave St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) ~~WIFE of~~: Erofele George

6 DATE OF BIRTH (month, day, and year): Unknown

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 43 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Confectionery

(b) General nature of industry, business, or establishment in which employed (or employer): 019

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Greece

PARENTS

10 NAME OF FATHER: George George

11 BIRTHPLACE OF FATHER (city or town) (State or country): Greece

12 MAIDEN NAME OF MOTHER: Georgie Trimis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Greece

14 Informant: Thomas George

(Address) 1st & Patapsco Ave Brooklyn

15 3/18 1927 G. HARRISON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 17th, 1927

17 I HEREBY CERTIFY, That I attended deceased from March 15th, 1927, to March 17th 27.

that I last saw him alive on March 17th, 1927.

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) — yrs. — mos 6 ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) — yrs. — mos. 4 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Tony Nebbel M.D.

3/18, 1927 (Address) 1224-26 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem. DATE OF BURIAL: March 19-27

20 UNDERTAKER: Margaret S. Fitzgerald ADDRESS: 1422 Light St

Spec.-7-17-26—A Co.—200 Bks.

E 20317

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

31

E 20317 REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1516 John St., 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara Gerting

(a) RESIDENCE NO. 1516 John St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. 10 mos. 24 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 Sex: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 23, 1903.

7 AGE: Years 23 Months 10 Days 24

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Geo. H. Minner

11 BIRTHPLACE OF FATHER (City or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Susie McCarthy

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Balto Md.

14 Informant: Mrs Jno. Berkemeyer (Address) 1516 John St

1927 C. HARRISON JONES, M. D. Registrar

Par BCH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: March 17/27

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1926 to 3/17/27 19.....

that I last saw h.. alive on 3/17/27 19.....

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 8 mos. 10 days

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Bernard J. Flynn, M. D.

3/17/27 (Address) 910 W. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem. Date of Burial: Mar. 19 1927

20 UNDERTAKER: Margaret J. Flynn ADDRESS: 1422 Light St

Spec.—12-9-25—A Co.—200 Blks.

E 20318 HEALTH DEPARTMENT—CITY OF BALTIMORE E 20318

CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS [redacted] 18-26 REGISTERED NO. 1001

City of BALTIMORE: (No. [redacted] St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John McLaughlin

(a) RESIDENCE NO. 943 W. Lombard St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widowed |

4a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1849

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 78 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plaster

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Ireland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant BALTIMORE CITY HOSPITALS

(Address) [redacted] Place

Date 3-9 1927 C. HARRISON JONES, M. D.

Per ARR Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11 1927

17 I HEREBY CERTIFY, That I attended deceased from April 30, 1926, to March 11, 1927, that I last saw him alive on March 11, 1927, and that death occurred, on the date stated above, at 3 30 P. m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral haemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? General & laboratory

(Signed) D Stoops Lamb M. D.

When 3-9 1927 (Address) BALTIMORE CITY HOSPITALS [redacted]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem. Date of Burial 3/21/1927

20 UNDERTAKER John F. Gowan & Son

Per F. J. Gowan ADDRESS 901 Hollins St.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20319

E 20319

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1516 S. Charles St. St. 23-32 Ward)

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Della.

(a) RESIDENCE NO. 1516 S. Charles St. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 10 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female. | White. | Widow. |

5a If ~~married, widowed, XXXXXXXX~~ (or) WIFE of John L. Della.

6 DATE OF BIRTH (month, day, and year) May 14, 1867.

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 59 | 10 | 8 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Frederick Smith.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Do not know.

14 Informant J. Morris Della. (son)

(Address) 1516 S. Charles St.

15 1927 C. HAMPSON JONES, M. D.

Par A C H Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ~~her~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pistol shot wound in the head.
Suicide.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner)

8/17 1927 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery Date of Burial Mar 21 1927

20 UNDERTAKER John F. Denny ADDRESS 715 Eglad

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20320

100-001

E 20320

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Pronounced dead on arrival at Franklin Sq. Hospital

City of BALTIMORE: (No. ____ St. ____ Ward ____)

REGISTERED NO. ____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Evelyn Marie Royster

(a) RESIDENCE NO. 706 N. Mount St. Ward ____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col'd

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Sept 6th 1926

7 AGE: Years —; Months 6; Days 11; IF LESS than 1 day ____hrs. or ____min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer): ____

(c) Name of employer: ____

9 BIRTHPLACE (city or town): Balto

(State or country): Md

PARENTS

10 NAME OF FATHER: Henry Royster

11 BIRTHPLACE OF FATHER (city or town): N. C.

(State or country)

12 MAIDEN NAME OF MOTHER: Eula Royster

13 BIRTHPLACE OF MOTHER (city or town): N. C.

(State or country)

14 Informant: Henry Royster

(Address): 706 N. Mount St

I hereby certify that I attended deceased from Mch 16 1927 to Mch 18 1927 that I last saw her alive on Mch 16 1927 and that death occurred on the date stated above, at 1 P.M.

C. HARRISON JONES, M. D.

Mch 19 1927 Per ARR Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/17/1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained at the Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho - Pneumonia

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) ____ (duration) ____ yrs. ____ mos. ____ ds.

(Signed) Thos B. Norton M. D. (Coroner)

Mch 18 1927 (Address) Curtis Bay, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? ____

Former or usual residence ____

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Lebanon Date of Burial Mch 19 1927

20 UNDERTAKER: Conner & Leyfield ADDRESS 364 N Carey

Spec.—1-10-21—M&T—1500 Bks.

E 20321 HEALTH DEPARTMENT—CITY OF BALTIMORE E 20321

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 240 S. Ann st. St. 6-9 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margret Bialecka

(a) RESIDENCE NO. 240 S. Ann st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Femal. 4 COLOR OR RACE: White 5 Single, Married, Widowed, or Divorced, (write the word): married.

5a If married, widowed, or divorced (or) WIFE of: Stefan Bialecki

6 DATE OF BIRTH (month, day, and year): May 18 - 1877.

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 49 | 10 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Hous Work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Poland.

PARENTS

10 NAME OF FATHER: Mateusz Wojciechowski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ——

14 Informant: Stefan Bialecki (Address) 240 S. Ann st.

15 Filed 9 1927 C. HAMPSON JONES, M. D. Registrar Per ——

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 18 1927

17 I HEREBY CERTIFY, That I attended deceased from March 6, 1927. to March 18. 1927.

that I last saw her alive on Mar 15 1927.

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary): Pulmonary Congestion

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. M. Dellett M. D.

(Address) 621 Washington Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary. DATE OF BURIAL: March 21 1927.

20 UNDERTAKER: George A. Weber. ADDRESS: 915 Bank St

Spec.-7-17-26—A Co.—200 Blks.

# E 20322

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

60-E-20322

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. H-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Reginald Booley

(a) RESIDENCE NO. 22 New Pittsburgh Ave St. Dundalk - MD Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Evelyn Booley

6 DATE OF BIRTH (month, day, and year) Dec 22, 1883

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|---|
| | 43 | 2 | 26 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Steel Co

9 BIRTHPLACE (city or town)

(State or country) England

PARENTS

10 NAME OF FATHER John Booley

11 BIRTHPLACE OF FATHER (City or town)

(State or country) England

12 MAIDEN NAME OF MOTHER Richmond

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) England

14 Informant Evelyn Booley

(Address) Dundalk Md

15 Filed 9 1927 C. HAMPSON JONES, M. D. Registrar

Per RKH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18 1927

17 I HEREBY CERTIFY, That I attended deceased from March 3, 1927, to March 18, 1927

that I last saw h in alive on March 18, 1927,

and that death occurred, on the date stated above, at 3:15 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial failure and acute thyroid toxicosis

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) acute thyroid toxicosis (duration) yrs. 4 mos. da.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Yes Date of 3-16-27

Was there an autopsy? no

What test confirmed diagnosis? Operation & Clinically

(Signed) R. S. Anderson M. D.

, 19 (Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Date of Burial Nov 21 1927

20 UNDERTAKER W. M. Cook ADDRESS 5022 Harford

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20323

## CERTIFICATE OF DEATH

90 E 20323

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Hillen Road St., 27-43 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah E Graham

(a) RESIDENCE NO. Hillen Road St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | W. | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dr Hugh Graham

6 DATE OF BIRTH (month, day, and year) Apr 5. 1843

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..hrs. or ..min.. |
|---|---|---|---|---|
| 83 | 84 | 11 | 13 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home Wid

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ohio

(State or country)

PARENTS

10 NAME OF FATHER David Hull

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER Julia Smith

13 BIRTHPLACE OF MOTHER (city or town) Penna

(State or country)

14 Informant Johnson H Myers

(Address) Dublin Md

15 Filed 1927 C. HARRISON JONES, M. D. Registrar

Per APA

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 1, 19 27, to Mar 15, 19 27, that I last saw h.. alive on Mar 15, 19 27, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Degeneration

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas Evans M. D.

3/18 1927 (Address) 4 7 N Howard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fredericksburg Ohio

Date of Burial 3/19 1927

20 UNDERTAKER Wm Cook

ADDRESS 502 E North Ave

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20324

E 20324

## CERTIFICATE OF DEATH

1-PLACE OF DEATH Colonial Hospital REGISTERED NO. 15-2

City of BALTIMORE: (No. 1122 No. Mount St. 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roland Carson

(a) RESIDENCE NO. 1535 Mendenhall St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1915

7 AGE: Years 12 Months Days

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Boy

(b) General nature of industry, business, or establishment in which employed (or employer): NO

(c) Name of employer

9 BIRTHPLACE (city or town): Balto (State or country) Md

PARENTS

10 NAME OF FATHER: William B Carson

11 BIRTHPLACE OF FATHER (City or town): (State or country) Md

12 MAIDEN NAME OF MOTHER: Verta Harmon

12 BIRTHPLACE OF MOTHER (city or town): (State or country) N J

14 Informant: Verta Carson (Address) 1542 Mendenhall St

15 1927 C. HARRISON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/17 1927

17 I HEREBY CERTIFY, That I attended deceased from 3/10, 1927, to 3/17, 1927, that I last saw h[illegible] alive on 3/17, 1927, and that death occurred, on the date stated above, at 12:45 P m.

The CAUSE OF DEATH* was as follows:

Septicaemia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Culture

(Signed) John W. Watson, M. D.

. 19 (Address) 1122 No. Mount St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

Date of Burial: March 19 27

20 UNDERTAKER: Wm Cook

ADDRESS: 504 E north ave

Spec.—1-10-21—M&T—1500 Bks.

20325

# HEALTH DEPARTMENT—CITY OF BALTIMORE

16E 20325

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1817 Ramsay ST., 14-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lewis R. Wheary

(a) RESIDENCE No. 1817 Ramsay ST. 24th WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 6 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 24th 1926

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | — | 6 | 25 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) child

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Lewis R. Wheary

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Betty F. Begonia

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant Lewis R. Wheary

(Address) 1817 Ramsay

15 Filed . 19 HANSON JONES Registrar

9 1027 Cert

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17th 1927

17 I HEREBY CERTIFY, That I attended deceased from March 14, 1927, to March 17, 1927.

that I last saw him alive on March 16, 1927.

and that death occurred, on the date stated above, at 11:45 a. m.

The CAUSE OF DEATH* was as follows:

Inanition

since birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R. Gustav Diez, M. D.

(Address) 1509 W. Lombard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Loudon Park Cemetery | March 19th 1927 |

20 UNDERTAKER F. D. Heffner ADDRESS 1850 W. Baltimore St

Cor.—12-9-25—A Co.—200 Bks.

E 20326

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20326

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 312 N. Parish St. 14-27 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Adella Brice

(a) RESIDENCE NO. 312 N. Parish St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Col'd | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 30th 1879

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 47 | 9 | 16 | 18 |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundry Work

(b) General nature of industry, business, or establishment in which employed (or employer) 041

(c) Name of employer

9 BIRTHPLACE (city or town) Annapolis, Md

(State or country)

PARENTS

10 NAME OF FATHER John H. Brice

11 BIRTHPLACE OF FATHER (city or town) Annapolis, Md

(State or country)

12 MAIDEN NAME OF MOTHER Kate Thomas

13 BIRTHPLACE OF MOTHER (city or town) St. Mary's Co. Md

(State or country)

14 Informant Mattie Cooper

(Address) 402 N. Stricker St

15 Filed ..... 19 ..... Registrar

MAR 19 1927

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16th 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

Half hour

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Duration yrs. mos. ds.

March 16th 1927 (Signed) Thos B. Norton M. D.

(Coroner)

(Address) Curtis Bay, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Mt. Zion Cemetery | May 19 1927 |

20 UNDERTAKER Mrs Katie R. Williams ADDRESS 322 N. Schroeder St

Spec.—1-12-23—M&T—500 Bks.

E 20327 HEALTH DEPARTMENT—CITY OF BALTIMORE E 20327

CERTIFICATE OF DEATH.

47

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2104 Lemmid Hill Ave. Sec. 13-59 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Anderson

(a) RESIDENCE NO. 2104 Lemmid Hill Ave STR. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | Col | Married |

5a If married, widowed, or divorced HUSBAND of or) WIFE of Wm. H. Anderson

6 DATE OF BIRTH (month, day, and year) Dec. 1874

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or ..... min. |
|---|---|---|---|---|
| | 52 | 11 | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER James D. Hanson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Lucretia Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

PARENTS

14 Informant Somerfield Hanson

(Address) 2104 Lemmid Hill Ave

15 Filed 9 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-17- 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 2- , 1927 , to Mar 17- , 1927 , that I last saw her alive on Mar 16- , 1927 , and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast.

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. Hargis, M. D.

(Address) 611 N. Carey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel

DATE OF BURIAL March 3 1927

20 UNDERTAKER John W Henderson

ADDRESS 1501 E Monument

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20328

## CERTIFICATE OF DEATH.

74 E 20328

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1529 Barclay ST. 12-19 WARD)

2-FULL NAME Sallie Cook.

(a) RESIDENCE NO. 1529 Barclay ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | C. | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 6 1906

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 19 | 2 | 11 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Henry Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Helen Wyatt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Maggie Hamill

(Address) 1529 Barclay

15 FILED 9 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 17 1927

17 I HEREBY CERTIFY, That I attended deceased from March 12. 1927. to March 17. 1927.

that I last saw h alive on March 17. 1927.

and that death occurred, on the date stated above, at 10.15 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Paralysis

(duration) 1 yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Paralysis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) D. W. Kennard, M. D.

3-19. 1927 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Potaury Co Va. | Mar 19, 1927 |

20 UNDERTAKER Wm. R. A. Ellis ADDRESS 175 Ashland av.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20329

E 20329

## CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1311 Aliceanna ST. 3-4 WARD)

2-FULL NAME Thomas Dobrochowski

(a) RESIDENCE NO. 1311 Aliceanna ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? 47 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | Married |

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline Dobrochowski

6 DATE OF BIRTH (month, day, and year) December 16 1856

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 70 | 3 4 | 7 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

10 NAME OF FATHER Joseph Dobrochowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Does know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Caroline Dobrochowski 1311 Aliceanna St

Filed 9 1927, 19 Per C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 1927

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1927, to March 16, 1927, that I last saw him alive on March 16, 1927 and that death occurred, on the date stated above, at 10 45 m.

The CAUSE OF DEATH* was as follows:

Apoplexy -

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (secondary) Senility Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo. L. Valentine, M. D.

(Address) 14 So Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross — DATE OF BURIAL March 21 1927

20 UNDERTAKER Wendell Offelsohn — ADDRESS 378 Lan

Spec.—8-24-14—M. & T.—2000 Bks.

E 20330

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20330

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 208 N Edmondson Ave. St.; 6-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME — Parks

(Residence in Baltimore: No. 208 N Edmondson Ave St.; ....yrs. ....mos. ....da.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH, March 17, 1921
(Month) (Day) (Year)

7-AGE, ✓ yrs. ✓ mos. ✓ da.

If LESS than 1 day, ....hrs. or 3 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ✓
(b) General nature of industry, business, or establishment in which employed (or employer) ✓

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Walter Parks

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Gladys Tyler

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter Parks

(Address) 208 N Edmondson Ave

15- 9 1927 C. HAMPSON JONES, M. D.
By ..... Registrar.

118

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 17, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 17 1921, to March 17 1921, that I saw h[illegible] alive on March 17 1921, and that death occurred, on the date stated above, at 9.55 m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(Duration) ✓ yrs. ✓ mos. ✓ da.

CONTRIBUTORY (Secondary) Premature Birth

(Duration) ✓ yrs. ✓ mos. ✓ da.

(Signed) Ralph L Straight M. D.

March 18, 1921 (Address) 26 E Preston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONAL TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....da. In the State ....yrs. ....mos. ....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, ....., 191...

20-UNDERTAKER ADDRESS

UNIVERSITY OF MARYLAND
Commissioner Health.

AUG 18 1921

MAR 18

Spec.—1-12-23—MAT—500 Blks.

E 20331

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20331

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2532 Madison Ave ST. 13-59 WARD)

REGISTERED NO. 44

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Euphemia Buckley

(a) RESIDENCE No. 2532 Madison Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 4 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced HUSBAND of or) WIFE of: David J Buckley

6 DATE OF BIRTH (month, day, and year): Nov 7th 1850

7 AGE — Years: 76 — Months: 4 — Days: 10 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Baltimore Md

10 NAME OF FATHER: David Mathew McKeldin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Marcella A Gross

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

Informant: Alice Arizona Buckley

(Address) 2532 Madison Ave

Filed 9-1927 C. HAMPSON JONES, M. D. Registrar

Per ABH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 17th 1927

17 I HEREBY CERTIFY, That I attended deceased from March 1st, 1926, to March 17th, 1927, that I last saw h[er] alive on March 17th, 1927, and that death occurred, on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 1 yrs. mos 18 ds.

CONTRIBUTORY (Secondary): Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Chas H Bulgart, M. D.

(Address) 1100 N. Lafayette Ave March 18 1927

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Mar 21 1927

20 UNDERTAKER: Harry N Arnsdorf — ADDRESS: 4204 Pulaski Ave

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20332

## CERTIFICATE OF DEATH.

188-003

E 20332

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hosp St. 4-26 Ward)

2-FULL NAME Madeline ~~Bad~~ Jacobi

(a) RESIDENCE NO. 229 Fremont St. South Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Md

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 16, 1869

7 AGE: Years 57 Months Days 30 (Under 1 year)

IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cloak Seller

(b) General nature of industry, business, or establishment in which employed (or employer): Own

(c) Name of employer

9 BIRTHPLACE (city or town): Germany

(State or country)

PARENTS

10 NAME OF FATHER per Hosp

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER C. Frankfurter

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Interment Anna M. Hebrew

(Address) 33 05 Granby Ave

C. HAMPSON JONES, M. D.

9 1927 By RRH Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Incest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Incest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Fract femur accidentally sustained (Operation) Dec 13/26 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia (duration) yrs. mos. ds.

(Signed) H. Phe, M. D.

(Coroner)

Dec 14, 1927 (Address) 1629 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) Since Dec 13 '27

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem Date of Burial 12/21/1927

20 UNDERTAKER: Geo A Farley Fulton & Fayette ADDRESS

Spec.—12-9-25—A Co.—200 Blks.

E 20333

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20333

## CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St. 7-2 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lama Green

(a) RESIDENCE NO. 517 W. Lanvale St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Negro | ? |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Widowed

6 DATE OF BIRTH (month, day, and year) 1857

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 70 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Nichols

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Rachel —

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Maryland

14 Informant BALTIMORE CITY HOSPITALS

(Address) [redacted] Records

Filed 1927 C. HAMPSON JONES, M. D.

Per _____ Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18 1927

17

I HEREBY CERTIFY, That I attended deceased from January 5, 1927, to March 18, 1927, that I last saw h-m alive on March 17, 1927, and that death occurred, on the date stated above, at 3.45 p. m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) ? yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) ____ yrs. ____ mos. 4 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of _____

Was there an autopsy?

What test confirmed diagnosis? general & laboratory

(Signed) R. Hobson Smith M. D.

March 22 1927 BALTIMORE CITY HOSPITAL

[redacted]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Catonsville Md

Date of Burial 3/20 1927

20 UNDERTAKER Samuel Kennedy

ADDRESS 538 Biddle

Cor.—12-9-25—A Co.—200 Bks.

E 20334

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 20334

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 697 W Fulberry St. 17-26 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jesse White Jr

(a) RESIDENCE NO. 697 W Fulberry St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 5 - 1853

7 AGE: Years 44 Months 4 Days 13 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shoedon

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Chesterton

(State or country): Md

PARENTS

10 NAME OF FATHER: Jesse White

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Md

12 MAIDEN NAME OF MOTHER: Jessie Lewis

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Md

14 Informant: Julia Nash

(Address) 697 W Fulberry St

15 Filed: C. HAMPSON JONES, M. D. Registrar

Pay

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/17 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Samuel D Hawks M. D.

(Coroner)

, 1927 (Address) 2325 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem

Date of Burial: 3/19 1927

20 UNDERTAKER: Samuel D Hawks

ADDRESS: W Balto

Spec.—12-9-25—A Co.—200 Blks.

E 20335

(James. Means)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20335

45

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospitals 8-16 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Means

(a) RESIDENCE No. 916 W Mulberry St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced (write the word): Wid

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unk

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 49 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): N. C.

(State or country) —

PARENTS

10 NAME OF FATHER: Lom Means

11 BIRTHPLACE OF FATHER (city or town): N. C.

(State or country)

12 MAIDEN NAME OF MOTHER: Julia Boyce

13 BIRTHPLACE OF MOTHER (city or town): N. C.

(State or country)

14 BALTIMORE CITY HOSPITALS

Informant [redacted] Records

(Address)

15 Filed 1927 C. HAMILTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3-16-27

17 I HEREBY CERTIFY, That I attended deceased from 2-23-27, to 3-16, 1927

that I last saw h[illegible] alive on 3-16, 1927

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Coronary Sclerosis

(duration) [illegible]

CONTRIBUTORY (Secondary) Senility Broncho

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Dr Laupus M. D.

, 19 (Address) Balto City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Ziona Cy Date of Burial 1927 March

20 UNDERTAKER: Leonard Wheeler ADDRESS 803 Myrtle Av

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20336

E 20336

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St., 16-37 Ward)

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME William Patton

(a) RESIDENCE NO. [redacted] St. Ward

(Usual place of abode) [redacted] (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1866

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 61 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Penna

PARENTS

10 NAME OF FATHER William Patton

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Marlow

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant BALTIMORE CITY HOSPITALS

(Address) [redacted] Records

15 Filed ..., 1927 C. HAMPSON JONES, M. D. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18 1927

17

I HEREBY CERTIFY, That I attended deceased from September 17 1926, to March 18, 1927, that I last saw him alive on March 18, 1927, and that death occurred, on the date stated above, at 11.45 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
Cutirial Sclerosis

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY Bronchopneumonia
(Secondary)

(duration) ...yrs. ...mos. 6 ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? general & laboratory

(Signed) R. Hooper Smith, M. D.

Mar. 19 27 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wilmington, Del. Date of Burial 3.9 1927

20 UNDERTAKER Wm. J. Turner & Sons ADDRESS [illegible]

Spec.—6-9-19—H. P. Co.—1000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20337 E 20337

## CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Washington Blvd Baltimore ST. 25-22 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

REGISTERED NO.

2-FULL NAME Sue Wade

(a) RESIDENCE. No. Washington Blvd. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Female | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William H Wade

6 DATE OF BIRTH (month, day, and year) 1852 July 26

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 74 | 7 | 22 | |

8 OCCUPATION OF DEACESED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Levi Kesler

11 BIRTHPLACE OF FATHER (city or town) (State or country) D.C.

12 MAIDEN NAME OF MOTHER Mary Catherine Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known.

14 Informant Clarence S Downey
(Address) Washington Blvd

15 Filed 9 1927 C. HAMPSON JONES, M. D. (Registrar)
By ACB

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18 1927

17 I HEREBY CERTIFY, That I attended deceased from March 1 1927 to March 18 1927, that I last saw her alive on March 16 1927, and that death occurred, on the date stated above, at 2.30 a. m.

The CAUSE OF DEATH* was as follows:

Arteritis

(duration) 5 yrs. 6 mos. — ds.
CONTRIBUTORY (Secondary) Arteriosclerosis Heart Lesions

(duration) — yrs. 2 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Signs & Symptoms.

(Signed) Raymond Grimes, M. D.
March 18, 1927 (Address) Oakland.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| London Park Cemetery | March 20 1927 |
| 20 UNDERTAKER | ADDRESS |
| Jos Soerdens & Son | 2173 N. Ave |

Cor.—12-9-25—A Co—200 Bks.

E 20338

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 20338

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St., 6-9 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Meyer Prastock

(a) RESIDENCE NO. 311 N. Eden St St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXXX

6 DATE OF BIRTH (month, day, and year) Feb 4/27

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | | 1 | 14 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md

PARENTS

10 NAME OF FATHER Herman Prastock

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Eva Frishman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant

(Address) Hospital Records

15 1927 C. HAMPSON JONES, M. D.

Per _____ Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 Mar 18/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (Primary)

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) ..... M. D.

(Coroner)

3/19/27 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Southern Aol Date of Burial 3/20 1927

20 UNDERTAKER H. J. Gunsor ADDRESS 1320 E Baltimore

Spec.—12-9-25—A Co.—200 Blks.

McCulloh

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20339

101-01

E 20339

CERTIFICATE OF ~~DEATH~~.

REGISTERED NO.

1-PLACE OF DEATH Mercy Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. 3-5 St. Ward)

2-FULL NAME John McCulloh

(a) RESIDENCE NO. 1338 Pratt St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unkn. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M.

4 Color or Race White

5 Single, Married, Widowed, or Divorced, (write the word) Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1876

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 51 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Next of Kin

(Address)

15 Filed 2 0 1927 C. HAMILTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16 1927

17 I HEREBY CERTIFY, That I attended deceased from March 14 1927, to March 16, 1927, that I last saw h alive on March 16, 1927, and that death occurred, on the date stated above, at 6.20 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) G. Moale M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Date of Burial 3-20 1927

20 UNDERTAKER Leo A Harley ADDRESS 1838 W Fayette

Spec.—7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

E 20340

## CERTIFICATE OF DEATH

E 20340

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: No. 626 N. Robinson St. 6-11 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Goldsworthy

(a) RESIDENCE NO 626 N. Robinson St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Paul Goldsworthy

6 DATE OF BIRTH (month, day, and year): Nov. 1852

7 AGE — Years: 74 — Months: 4 — Days: — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Frostburg, (State or country) Md

PARENTS

10 NAME OF FATHER: Francis Brosgue

11 BIRTHPLACE OF FATHER (City or town): (State or country) Ireland

12 MAIDEN NAME OF MOTHER: Mary Ellen Brosgue

13 BIRTHPLACE OF MOTHER (city or town): (State or country) Md

14 Informant: Eliz. Gallagher

(Address) 626 N. Robinson St

15 FEB 20 1927 C. HAMILTON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 19 1927

17 I HEREBY CERTIFY, That I attended deceased from March 16, 1927, to March 19, 1927,

that I last saw h[illegible] alive on March 19, 1927,

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Edema of lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm Nelson, M. D.

2/27 1927 (Address) 701 Mt. Vernon Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cumberland, Md — Date of Burial 3/[illegible] 1927

20 UNDERTAKER: J. A. Moran — ADDRESS 30 E Baltimore St

Spec.—1-10-21—M&T—1500 Blks.

#20341 E 20341

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

✓ X 91 00 ✓ E 20341

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4715 Edmondson Ave. ~~28~~ 71 WARD)

2-FULL NAME Mary E. Hopkins

(a) RESIDENCE NO. 4715 Edmondson Ave ST., WARD Delaware.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Hopkins

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 89 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Seaford, Del.
(State or country)

PARENTS

10 NAME OF FATHER William Hazzard

11 BIRTHPLACE OF FATHER (city or town) Seaford
(State or country) Del

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Bridgeville Del.
(State or country)

14 Informant Robert G. Hopkins
(Address) 904 E. 41st St

Filed 20-1927, 19 C. HARRISON JONES, M. D. Registrar
Per RM

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19, 1927

17 I HEREBY CERTIFY, That I attended deceased from March 5th, 1927, to March 19, 1927.

that I last saw her alive on March 18, 1927,

and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Arteriosclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. L. Pearson, M. D.

March 19, 1927 (Address) 514 Drury Lane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Odd Fellows — DATE OF BURIAL Mar. 21 1927

UNDERTAKER H. L. Watson, Jr. — ADDRESS Seaford Del

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20342

## CERTIFICATE OF DEATH.

90 E 20342

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 528 N. Caroline ST. 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma J. Woolford

(a) RESIDENCE NO. 528 N Caroline ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | C | Married. |

5a If married, widowed, or divorced (or) WIFE of John A. Woolford

6 DATE OF BIRTH (month, day, and year) unknown

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | uppox 50 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Benj Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Ellen Woolford (sister in law)

(Address) 528 N Caroline St

15 Filed 20 1927 C. HARRY JONES, M. D. Registrar

Per KJC

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18 1927

17 I HEREBY CERTIFY, That I attended deceased from March 18, 1927, to March 18, 1927, that I last saw h[illegible] alive on March 18, 1927, and that death occurred, on the date stated above, at 3:50 A. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac dilitation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral insufficiency and hypertension (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Physical

(Signed) R J C M. D.

3/19, 1927 (Address) 1 Troy Entrance

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem.

DATE OF BURIAL 3/21/1927

20 UNDERTAKER Byron Wright

ADDRESS 1218 McElderry St

Spec.—6-9-19—H. P. Co.—1000 Bks.

Bauer.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20343

## CERTIFICATE OF DEATH.

90

E 20343

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 408 Henderson St. 17-50 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Bauer

(a) RESIDENCE. NO. 408 Henderson ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Delia E. Bauer

6 DATE OF BIRTH (month, day, and year) April 2-1859

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 67 | 11 | 15 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Superintendent

(b) General nature of industry, business, or establishment in which employed (or employer) Auto Painting

(c) Name of employer Cadillac Co.

9 BIRTHPLACE (city or town) (State or country) Harford Co. Md.

PARENTS

10 NAME OF FATHER Frank Bauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Schreiner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mrs. Delia E. Bauer, 408 Henderson St.

15 Filed . 19 C. HARTMAN JONES, M. D. Registrar

0 1927 Per R.H.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 . 1927. to March 17 . 1927.

that I last saw him alive on March 16 . 1927.

and that death occurred, on the date stated above, at 5-25 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Myocarditis
High blood pressure

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Walter S Tublitt, M. D.

March 17/27 . 19 (Address) 2220 Garrison Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Cathedral Cemetery, | Mar. 21, 1927 |
| 20 UNDERTAKER | ADDRESS |
| Elmer R. Wonkelin, | 924 E. Eager St. |

Spec.—12-9-25—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20344

## CERTIFICATE OF DEATH.

101-001 E 20344

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home & Infirmary St., Ward)

2-FULL NAME Mrs Lola K. Patton

(a) RESIDENCE NO. 3704 Gwynn Oak Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert B. Patton

6 DATE OF BIRTH (month, day, and year) May 19 1861

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 65 | 9 | 28 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) Rensselaer

(State or country) Indiana

PARENTS

10 NAME OF FATHER Gordon A. Moss

11 BIRTHPLACE OF FATHER (city or town)

(State or country) New Richmond Ohio

12 MAIDEN NAME OF MOTHER Lydia A Greenfield

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Muscumming Co. Ohio

14 Informant Robert B. Patton

(Address) 3204 Gwynn Oak ave

15 Filed 1927 [illegible] Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17, 1927

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1927, to March 17, 1927, that I last saw her alive on March 17, 1927, and that death occurred, on the date stated above, at 3:30 p m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Damon H. Norwood, M. D.

March 17 1927 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rensselaer Indiana Date of Burial March 20, 1927

20 UNDERTAKER Chas. G. Black ADDRESS 742 W. North ave

Spec.—8-24-14—M. & T.—2000 Bks.

E 20345

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 20345

## CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4109 Boarman Ave St. 31-63 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Pauline E Thomas

(Residence in Baltimore: No. 4109 Boarman Ave St.: 72 yrs., 1 mos. 2 ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

| 3-SEX | 4-COLOR OR RACE | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) |
|---|---|---|
| Female | White | Married |

6-DATE OF BIRTH, February (Month) 17 (Day), 1855 (Year)

7-AGE, 72 yrs. 1 mos. 2 ds. If LESS than 1 day, ....hrs. or.....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work Housework (b) General nature of industry, business, or establishment in which employed (or employer) Home

9-BIRTHPLACE, (State or Country), Baltimore, Md

PARENTS.

10-NAME OF FATHER, John H. Slater

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER Harriet Reay.

13-BIRTHPLACE OF MOTHER (State or Country), England.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert Thomas

(Address) 4109 Boarman ave

15- Filed MAR 20 1927, 191.... C. HARRY JONES, M. D. Registrar. By ....

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 19 (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 14 1927, to March 19 1927, that I saw her alive on March 19 1927, and that death occurred, on the date stated above, at 10:30 P.m.

The CAUSE OF DEATH* was as follows:

Septic Bronchitis following Pneumonia (Broncho)

(Duration) ....yrs. ....mos. 6 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(Duration) ....yrs. ....mos. 2 ds.

(Signed) H. C. Bellman M. D.

Mar 19, 1927 (Address) Towson, Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cemetery DATE OF BURIAL, March 23 1927

20-UNDERTAKER Chas. G. Black ADDRESS 742 Worthington ave

Spec.—1-12-23—M&T—500 Blks.

20346

# HEALTH DEPARTMENT—CITY OF BALTIMORE

74E 002 20346

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Charles & Belvedere Westport ST. 5-32 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Price

(a) RESIDENCE NO. Charles Belvedere West Port ave WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of John Price

6 DATE OF BIRTH (month, day, and year) December 26 1865

7 AGE

| Years | Months | Days | If LESS than 1 day, ....hrs or ....min. |
|---|---|---|---|
| 61 | 2 | 17 21 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Keeping

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

10 NAME OF FATHER Martin Ratdhra

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Lonsa Hafe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

Informant Adam Stymerez

(Address) Charles & Belvedere ave

MAR 20 1927

Filed ..... Registrar RJL

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 10, 1927, to Mar. 16, 1927, that I last saw her alive on Mar 16, 1927, and that death occurred, on the date stated above, at 3/40 m.

The CAUSE OF DEATH* was as follows:

arteriosclerosis

(duration) 3 ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Thrombosis

(duration) 3 yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Edward Doran, M. D.

, 19 (Address) 1211 Eutaw pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross — DATE OF BURIAL March 21 1927

20 UNDERTAKER Wendell Diffendal Son — ADDRESS 37 St

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20347

## CERTIFICATE OF DEATH

E 20347

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1316 Sargeant ST. 21-29 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vernon W. Woolford

(a) RESIDENCE NO. 13 16 Sargeant St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct October 9, 1925

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min.. |
|---|---|---|---|---|
| | I | 5 | IO | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Milton Woolford

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Denton Maryland

12 MAIDEN NAME OF MOTHER Alice Mathews

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Taylors Island

14 Informant Lena Mathews

(Address) 1316 Sargeant St

Filed MAR 28 1927 H. M. JONES, M. D. Registrar

By R R.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

March 19, 1927

17 I HEREBY CERTIFY, That I attended deceased from March 14/27, 19..., to March 19/27, 19...,

that I last saw him alive on March 19/27, 19...,

and that death occurred, on the date stated above, at 11.55 P m.

The CAUSE OF DEATH* was as follows:

Contusion (Coroner)

4hrs (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Not Known

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) John D. Woll, M. D.

(Address) 1203 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. Date of Burial March 23

20 UNDERTAKER Jos. B. Cook ADDRESS 1032 W. Balto St

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 20348 — 90 ✓ — E 20348

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 309 South Gilmor St. 19-28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John A. Stewart

(a) RESIDENCE NO. 309 South Gilmor St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rebecca G. Stewart

6 DATE OF BIRTH (month, day, and year) December 9, 1853

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|---|
| | 73 | 3 | 10 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Interior decorator

(b) General nature of industry, business, or establishment in which employed (or employer) 53

(c) Name of employer Mr. Hoffman

9 BIRTHPLACE (city or town) Baltimore,

(State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph Stewart

11 BIRTHPLACE OF FATHER (City or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret M. Stewart.

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Meryland

14 Informant J. C. Stewart

(Address) 309 South Gilmor Street

15 Filed ..... 19.. C. HARRY JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19, 1927

17 I HEREBY CERTIFY, That I attended deceased from March 11 19 27 to Mar 19 19 27

that I last saw him alive on Mar 19 19 27

and that death occurred, on the date stated above, at 2.26 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Hemiplegia - Hemorrhage of R. Brain (duration) one yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemiplegia - acute Hemorrhage of brain (duration) yrs. 4 mos. ds.

18 Where was disease contracted —

If not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Paralysis of left side

(Signed) Thos H Phillips, M. D.

3-19 1927 (Address) 2300 Edmondson Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Loudon Park Cemetery | Mar. 22 1927 |

20 UNDERTAKER Joseph H Cook ADDRESS 1003 W. Balto St

Spec. -7-17-26—A Co.—200 Bks.

E 20349

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

× 31 ✓

E 20349

1-PLACE OF DEATH Womans Hospital. REGISTERED NO.

City of BALTIMORE: (No. 14-20 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Belle Light.

(a) RESIDENCE NO. 626 Carroll Ave. St. Takoma Park, M.C. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~6~~ yrs. mos. 7 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Elsworth Light

6 DATE OF BIRTH (month, day, and year) July 24th, 1865.

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 61 | 7 | 23 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Libertyville ~~Ind~~

(State or country) Indiana.

PARENTS

10 NAME OF FATHER Joseph Hearne

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Indiana

12 MAIDEN NAME OF MOTHER ~~Mahana Dowdy~~ Mahana Dowdy

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) New Goshen, Ind.

14 Informant Daughter

(Address) Womans Hospital

15 Filed MAR 20 1927 C. H. [illegible] JONES, M. D. Registrar

Per K M

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 12th, 1927, to Mar 19th, 1927, that I last saw her alive on Mar 14th, 1927, and that death occurred, on the date stated above, at 4:25 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum exam. X-ray chest

(Signed) Edmund R. Harmon M. D.

3/19, 1927 (Address) Womans Hosp. Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

Pulmonary Tuberculosis

19 PLACE OF BURIAL, CREMATION OR REMOVAL Little Grove Cem. Edgar Co. Ill Date of Burial Mar 20 1927

20 UNDERTAKER Joseph D Cook ADDRESS 1003 N Gilts St

Spec.—1-10-21 M&T 1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20350

## CERTIFICATE OF DEATH.

11-002

E 20350

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5318 (Street) Englewood St. (Ward) 24 Hamilton

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Otto Faust

(a) RESIDENCE NO. 5318 Englewood ST. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Faust

6 DATE OF BIRTH (month, day, and year) Feb 28 1871

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs or ..... min. |
|---|---|---|---|---|
| | 56 | | 17 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher

(b) General nature of industry, business, or establishment in which employed (or employer) 013

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER Otto Faust

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Tirch

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Bath. Home (Address) 5318 Englewood Ave

15 Filed ..... 19 C. HARRISON JONES, M.D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 17 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 8, 1927, to Mar 16, 1927, that I last saw h[illegible] alive on Mar 16, 1927, and that death occurred, on the date stated above, at 2 [illegible] p m.

The CAUSE OF DEATH* was as follows:

Acute Encephalitis

Type unknown

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Primary Influenza

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Edw H Gruen M. D.

3-18-1927 (Address) 120 Ausgild St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Parkwood Cemetery | March 21 1927 |
| 20 UNDERTAKER | ADDRESS |
| H Henry Lutz | N. Broadway |

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20351

## CERTIFICATE OF DEATH.

10 × 903

E 20351

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital ST., 9-45 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Logan Spivey

(a) RESIDENCE NO. Sparrows Point Road ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Non Resident yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 3, 1926

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs or ....min. |
|---|---|---|---|---|
| | | 9 | 17 16 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore County

PARENTS

10 NAME OF FATHER Logan Spivey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ky.

12 MAIDEN NAME OF MOTHER Mary Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Co.

14 Informant Mrs. Logan Spivey

(Address) Sparrowspoint Road

15 Filed MAR 20 1927 H. C. HAWKINS JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 1927

17 I HEREBY CERTIFY, That I attended deceased from March 18, 1927, to March 19, 1927.

that I last saw him alive on March 19, 1927

and that death occurred, on the date stated above, at 6 30 a m.

The CAUSE OF DEATH* was as follows:

Nasal - Laryngeal Diphtheria

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical - Pos. K. L. Cult.

(Signed) Myron G. Tull, M. D.

3/19, 1927 (Address) Sydenham Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Sulcidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL Mar 20 1927

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

Spec.—12-9-25—A Co.—200 Bks.

E 20352

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 ✓ E 20352

10-15

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St.) (T. O. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Dorsey

(a) RESIDENCE NO. 709 Forest st. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Colored | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1907

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 20 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Sam. Dorsey

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Carrie Rainbow

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed 20 1927 C. HAZEN JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from January 11 19 27 to March 16 19 27,

that I last saw her alive on March 16 19 27,

and that death occurred, on the date stated above, at 8.45 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous Enteritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed Diagnosis? Autopsy

(Signed) W. C. Gatewood, M. D.

3-16 27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Cockeysville Md. March 18 '27

20 UNDERTAKER ADDRESS

Jos. G. H. Rochester 1453 Jefferson st

Spec.—1-12-23—M&T—500 Blks.

E 20353 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

S 6 E 20353

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 116 E. Hamburg ST. 24 33 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hazel Lambdin

(a) RESIDENCE NO. 116 E Hamburg ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word)

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 10 1926

7 AGE: Years | Months 6 | Days 8 | If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Md.

10 NAME OF FATHER Albert Lambdin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Hazel Fleury

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Mrs. Fleury

(Address) 116 E Hamburg

Filed 3-26 1927 HAMSON R. JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/18- 1927

17

I HEREBY CERTIFY, That I attended deceased from 3/10- 1927, to 3/18- 1927,

that I last saw h[illegible] alive on 3/17- 1927

and that death occurred, on the date stated above, at m

The CAUSE OF DEATH* was as follows:

Tuberculosis

(duration) yr. — mos. — ds.

CONTRIBUTORY (Secondary) Rickets

(duration) — yrs. 2 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

, 19 (Address) 1340 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill

DATE OF BURIAL: 3/21 1927

20 UNDERTAKER: J. Frew McCully

ADDRESS: 130 E [illegible]

Spec.—7-17-26—A Co.—200 Bks.

Soifer

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20354

100-001

E 20354

## CERTIFICATE OF DEATH

1-PLACE OF DEATH University Hospital

REGISTERED NO.

City of BALTIMORE: (No. S. 6-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Phillip Soifer

(a) RESIDENCE NO. 404 N. Broadway St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S. if of foreign birth? 70 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White Jewish

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Hannah Soifer

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years: 51 Months: — Days: — IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Presser-clothes

(b) General nature of industry, business, or establishment in which employed (or employer): Self

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Hannah Soifer

(Address) 404 N. Broadway

15 Filed MAY 20 1927 19 HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/18/27 19

17 I HEREBY CERTIFY, That I attended deceased from 3/16/27, 19 to 3/18/27, 19

that I last saw him alive on 3/18/27, 19

and that death occurred, on the date stated above, at 1035 a.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Asthma

(duration) Several yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. S. Winstead M. D.

3/18, 1927 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Mt Carmel — Date of Burial: 3/20 1927

20 UNDERTAKER: Jack Lewis — ADDRESS: 1439 E. Lom[illegible]

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20355

## CERTIFICATE OF DEATH.

74001

E 20355

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital 13-59 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie Markowitz

(a) RESIDENCE NO. 2409 Lakewood ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth 35 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | white | married |

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Isreal Markowitz

6 DATE OF BIRTH (month, day, and year) dead

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 64 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia

10 NAME OF FATHER Markowitz

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Markowitz

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

Informant Isreal Markowitz

(Address) 2409 Lakewood ave

Filed ..... 19 C. HAMPSON JONES, Registrar

MAR 20 1927

By .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-19-1927

17

I HEREBY CERTIFY, That I attended deceased from 3-12, 1927, to 3-19, 1927, that I last saw her alive on 3-18, 1927, and that death occurred, on the date stated above, at 1 1/2 p. m.

The CAUSE OF DEATH* was as follows:

Intra Cranial Hemmorrhage

(duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis.

(duration) ? yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Harry Weintraub, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Int. Assoc. Date of Burial 3/20 1927

20 UNDERTAKER M. Jack Lewis ADDRESS 1739 E Baltimore

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

20356

100-001

## CERTIFICATE OF DEATH.

E 20356

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2604 Springhill ave ST. 15-56 WARD)

2-FULL NAME Samuel Goldman

(a) RESIDENCE No. 2604 Springhill ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah Goldman

6 DATE OF BIRTH (month, day, and year): Unk

7 AGE: Years 94 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): ood

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: Louis Goldman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Sarah —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Mrs Hannah Davis

(Address) 2604 Springhill ave

15 Filed MAR 20 1927 HAMILTON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/18 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 1st, 1924 to March 18 1927, that I last saw h[illegible]ive on March 17, 1927 and that death occurred, on the date stated above, at 10 P m

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

General Debility

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): Cardiac asthenia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Albert L. Levy, M. D.

3/19, 1927 (Address) 6 N Liberty St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship

DATE OF BURIAL: 3/20 1927

UNDERTAKER: D. Gall

ADDRESS: Lois 1439 E Baltimore St

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20357

## CERTIFICATE OF DEATH.

90

REGISTERED NO. E 20357

1-PLACE OF DEATH

City of BALTIMORE: (No.) Sinai Hospital St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adolph Silberger

(a) RESIDENCE NO. 1914 Eutaw Place St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | white | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Silberger

6 DATE OF BIRTH (month, day, and year) June 11 - 1868

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 58 | 9 | 7 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town)

(State or country) Austria

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Austria

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Austria

14 Informant Sol Silberger

(Address) 3816 Woodland Ave

15 Filed ..... 19 .....

Per ..... Registrar

C. HAMPSON JONES, M. D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from 3-6 19 27, to 3-18 19 27,

that I last saw h. alive on 3-18 19 27,

and that death occurred, on the date stated above, at 4:30 m.

The CAUSE OF DEATH* was as follows:

(a) Cerebral hemorrhage

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart failure

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H Edmund Lewis, M. D.

3/19 1927 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Hebrew Rm Date of Burial 3/20 1927

20 UNDERTAKER Jack Levi's ADDRESS 1439 E Baltimore

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

118-001

E 20358

## CERTIFICATE OF DEATH

E 20358

REGISTERED NO.

1-PLACE OF DEATH University Hospital

City of BALTIMORE: (No. 1 Lombard and Greene St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Zipper

(a) RESIDENCE NO. 820 E. Lombard St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Zipper

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..hrs. or ..min.. |
|---|---|---|---|---|
| | 70 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Russia

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Jacob Zipper

(Address) 820 E. Lombard St.

15 Filed MAR 20 1927 C. HAMILTON JONES, M. D. Registrar

Per RM

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 20th 1927

17 I HEREBY CERTIFY, That I attended deceased from 3-16, 1927, to 3-20, 1927, that I last saw him alive on 3-20, 1927, and that death occurred, on the date stated above, at 1:15 A m.

The CAUSE OF DEATH* was as follows:

Strangulated Inguinal Hernia, Acute Appendicitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(duration) yrs. mos 1½ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? YES Date of 3-16-27

Was there an autopsy? NO (Herniotomy)

What test confirmed diagnosis? Physical Signs

(Signed) W. E. Lemmon, M. D.

, 19 (Address) University Hosp. Balto, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mehrer Woodlawn — Date of Burial 3/20, 1927

20 UNDERTAKER Jack Louis — ADDRESS 1439 E. Balto St.

Very important. See instructions on back of certificates.

Cor.—12-9-26—A Co.—200 lbks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20359
1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

159 E 20359
REGISTERED NO.

City of BALTIMORE: (No. 1148 N. Stricker St., 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gertrude Watkins

(a) RESIDENCE NO. 1148 N. Stricker St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 15, 1927

7 AGE: Years — Months — Days: 4 — IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country): Md.

PARENTS

10 NAME OF FATHER Leonard Watkins

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Md.

12 MAIDEN NAME OF MOTHER Eliz. Brown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Md.

14 Informant Leonard Watkins
(Address) 1148 N. Stricker St

15 Filed ....., 19..... C. HAMPSON JONES, M. D.
Per ..... Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 19, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Patch foreman
Ovale.

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D.
(Coroner)

March 20, 1927 (Address) 2502 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Walker's chapel A. A. & md — Date of Burial: 3/20 1927.

20 UNDERTAKER: Mrs James N. Dennis & T. E. Nelson — ADDRESS: 1300 Pressman St

U 1927

Spec.—12-9-25—A Co.—200 Blks.

E 20360

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 20360

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 32 E. White Ave 27-43 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sallie O. Denton

(a) RESIDENCE NO. 32 E. White Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 71 yrs. 11 mos. 8 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of late John W. Denton

6 DATE OF BIRTH (month, day, and year): Apl 10/55

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 71 | 11 | 8 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of indnstry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER John Ward

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Lottie O. Denton

(Address) 32 E. White Av

15 Filed MAR 20 1927 HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/18/27 19

17

I HEREBY CERTIFY, That I attended deceased from 3/12/27, 19, to 3/18/27, 19,

that I last saw her alive on 3/18/27, 19, at 4:15 P. m.

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia, 1st lung

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pardiac dilation

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas Smith, M. D.

3/19/27 (Address) 4706 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn — Date of Burial: 3/21 1927

20 UNDERTAKER: Philip Henry — ADDRESS 2017 Orleans St.

Spec.—12-9-25—A Co.—200 Pks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 20361

E 20361

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 208 N. Glover St. 6-10 Ward)

2-FULL NAME Thos. P. Benny

(a) RESIDENCE NO. 208 N. Glover St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed or divorced HUSBAND of ~~(or WIFE of)~~ late Mattie Benny

6 DATE OF BIRTH (month, day, and year) June 10/53

7 AGE: Years 71 | Months 9 | Days 7 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): 015

(c) Name of employer

9 BIRTHPLACE (city or town) Easton Md

(State or country)

PARENTS

10 NAME OF FATHER Thos. Benny

11 BIRTHPLACE OF FATHER (city or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Mrs Cooper Elliott

(Address) 208 N. Glover St

15 Filed ..... 19 ..... Registrar

Per: C. HAMPTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 17/37

17 I HEREBY CERTIFY, That I attended deceased from 3-10 19 27, to 3-17 19 37

that I last saw h.. alive on 3-17 19 37

and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows: Bronchopneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) F. Reid Dunphy M. D.

19 27 (Address) 1004 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Date of Burial Mar 20/37

20 UNDERTAKER: Philip Hennig ADDRESS 2016 Orleans

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20362

## CERTIFICATE OF DEATH.

× 57

E 20362

REGISTERED NO.

1-PLACE OF DEATH Mercy Hospital

City of BALTIMORE: (No. 4 St., 47 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME John Wright

(a) RESIDENCE NO. Back River Rd. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah E. Wright

6 DATE OF BIRTH (month, day, and year) Dec. 11th 1867

| 7 AGE Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|
| 59 years. | 3 | 7 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter. 015

(b) General nature of industry, business, or establishment in which employed (or employer) General

(c) Name of employer

9 BIRTHPLACE (city or town) Virginia

(State or country)

PARENTS

10 NAME OF FATHER Morgan Wright

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant Sarah E. Wright

(Address) Stemmers Run

15 Filed 20 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18, 1927 19

17

I HEREBY CERTIFY, That I attended deceased from John Wright 1927, to 3-18 1927, 3-16

that I last saw ~~him~~ alive on 3-18-27, 19.....,

and that death occurred, on the date stated above, at 12 5th m.

The CAUSE OF DEATH* was as follows:

Myocardial failure

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) 3 yrs. mos. ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. Glassner, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery Date of Burial March 21, 1927

20 UNDERTAKER Fred'k Lansdowne Sons ADDRESS Fullerton Md.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20363

# CERTIFICATE OF DEATH.

100-09 E 20363

E 20363
1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore Gen. St. 27-53 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Skiley Cole

(a) RESIDENCE NO. 730 Wyndhurst St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)
Nov. 4, 1922.

| 7 AGE Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|
| 4 yrs | 4 | 15 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER E. Slan Cole.
11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland
12 MAIDEN NAME OF MOTHER Phyllis Spooner
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Conn.

14 Informant Parents
(Address) 730 Wyndhurst.

15 Filed ..... 19 HAMPSON JONES, M. D.
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19
March 19, 1927.

17 I HEREBY CERTIFY, That I attended deceased from March 16, 1927, to March 19, 1927, that I last saw h.. alive on March 19, 1927, and that death occurred, on the date stated above, at 12.20 P.m.

The CAUSE OF DEATH* was as follows:
Broncho-Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at Home
Did an operation precede death? NO Date of
Was there an autopsy? NO
What test confirmed diagnosis? Examination.
(Signed) H. E. Wright, M. D.
3/19, 1927 (Address) South Baltimore Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — Date of Burial 3/22 1927

20 UNDERTAKER William Cook — ADDRESS 502 E. Monument St.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

188-002

## CERTIFICATE OF DEATH.

E 20364

REGISTERED NO. E 20364

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital. St. 4-46 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Davis

(a) RESIDENCE NO. 1541 Homestead St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male. | White. | Married |

5a If married, widowed or divorced, HUSBAND of Mary Davis.

6 DATE OF BIRTH (month, day, and year) February 18, 1896.

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 31 | 0 | 22 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Milk wagon driver

(b) General nature of industry, business, or establishment in which employed (or employer): Fairfield Dairy.

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Pennsylvania.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Do not know.

14 Informant Mary Davis. (wife)

(Address) 1541 Homestead st.

15 Filed APR 20 1927 C. HAMPSON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17, 1927.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull.

Thrown from a milk wagon unfer a street-car in a collision between the same.

accidental Death (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner)

3/19 1927 (Address) 1017 E. Charles st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Lexington & High sts. Nov. 17, 1927.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Date of Burial Mar 21 1927

20 UNDERTAKER W. H. Cook ADDRESS 502 E. Madison Ave

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20365

## CERTIFICATE OF DEATH

E 20365

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 3214 E Lombard St. 16-2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Helen Naumann

(a) RESIDENCE NO. 3214 E Lombard St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred ~~1~~ yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Naumann

6 DATE OF BIRTH (month, day, and year): Mar. 23, 1851

7 AGE: 75 Years 76 Months 11 Days 26

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): Home.

(c) Name of employer

9 BIRTHPLACE (city or town): Falls, Md.

(State or country)

PARENTS

10 NAME OF FATHER: Rudolph Vinup

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Unknown

14 Informant: W. J. Harrod

(Address): 3214 E. Lombard St

15 Filed: 2 0 1927

C. HAMPSON JONES, Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 19-27 19

17 I HEREBY CERTIFY, That I attended deceased from Mch. 13-27, 19, to Mch. 19-27, 19

that I last saw her alive on Mch 18-27, 19

and that death occurred, on the date stated above, at 12.15 m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Uremia

(duration) yrs. mos. 14 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frederick W Thuman M. D.

Mch. 19 27 (Address) 719 E Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: B. Mathews, Md

Date of Burial: 19 27

20 UNDERTAKER: Wm Cook

ADDRESS: 601 E. Balto.

Spec.-7-17-26—A Co.—200 Bks.

E 20366

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 20366

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 204 W Rogers Ave St.) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa E. Hawkins

(a) RESIDENCE NO. 204 W. Rogers Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John S. Hawkins

6 DATE OF BIRTH (month, day, and year): Dec. 25. 1853

7 AGE: Years 73 Months 2 Days 23

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Churchville

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Patrick Clark

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Maryland

12 MAIDEN NAME OF MOTHER: Margaret Kerr

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Maryland.

14 Informant: Katie W. Hynes

(Address): 204 W. Rogers Ave.

15 Filed ..... 19 .....

MAR 20 1927 HAMPSON JONES, M. D. Registrar

For

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 18 19 27

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 19 27, to Mar 18, 19 27

that I last saw her alive on Mar 18, 19 27

and that death occurred, on the date stated above, at 3.55 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Disease of Heart

(duration) 2 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physicians.

(Signed) Sidney B. Street M. D.

3/19, 1927 (Address) 445 E Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Churchville, Norford Co

Date of Burial: 3/21 1927

20 UNDERTAKER: W. W. Cook

ADDRESS 522 E Fort Ave

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20367

CERTIFICATE OF DEATH.

89 E 20367

1-PLACE OF DEATH

REGISTERED NO._____

City of BALTIMORE: (No. 122 Clear View Ave. Ward) 27-43

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Florence Yates

(a) RESIDENCE NO. 122 Clear View Ave Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William Yates

6 DATE OF BIRTH (month, day, and year): June 5 1864

7 AGE: Years 62 | Months 11 | Days 12 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town): England

(State or country)

PARENTS

10 NAME OF FATHER: ? Bellew

11 BIRTHPLACE OF FATHER (city or town): England

(State or country)

12 MAIDEN NAME OF MOTHER: Louise Hillman

13 BIRTHPLACE OF MOTHER (city or town): England.

(State or country)

14 Informant (Address): Mrs Florence Yates 122 Clear View Ave

Filed 3 20 1927 C. HAMPSON JONES, M. D. Registrar

Per

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/17 1927

17 I HEREBY CERTIFY, That I attended deceased from 2/1 1927, to 3/17 1927,

that I last saw her alive on 3/17 1927,

and that death occurred, on the date stated above, at 10.30 A. hr.

The CAUSE OF DEATH* was as follows: Angina Pectoris

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pleurisy

(duration) yrs. mos. ds.

18 Where was disease contracted ?

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Kyle W. Bellew, M. D.

, 19 (Address) 5012 Harford Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudenslager Date of Burial 3/20 1927

20 UNDERTAKER: W. H. Cook ADDRESS 502 E Northern Pky

Spec.—1-10-21—M&T—1500 Blks.

E 20368

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 E 20368

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 6 W. Gibbons ave (St.) 27-41 (WARD)

2-FULL NAME John W. Schueler

(a) RESIDENCE NO. 6 W. Gibbons ave ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 6 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | married |

5a If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE of~~ Agnes Schueler

6 DATE OF BIRTH (month, day, and year) Sept 29th 1867

| 7 AGE | Years | Months | Days | If LESS than 1 day, .... hrs. or .... min. |
|---|---|---|---|---|
| | 59 | 5 | 27 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar Manufacturer

(b) General nature of industry, business, or establishment in which employed (or employer) 017

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Louis Schueler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Catherine Berger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Mrs Agnes Schueler (wife)
(Address) 106 W. Gibbons ave

15 1927 C. HAMPSON JONES, M. D.
Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19th 1927

17

I HEREBY CERTIFY, That I attended deceased from ~ , 1911 , to March 19 , 1927 ,
that I last saw him alive on March 19 , 1927 ,
and that death occurred, on the date stated above, at 330P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 16 yrs. mos ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of ~

Was there an autopsy? No

What test confirmed diagnosis? P. E.

(Signed) John S. Rinehof M. D.

, 19 (Address) 930 N. Calvert.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Parkwood Cemetery | Mar 22nd 1927 |
| 20 UNDERTAKER | ADDRESS |
| George Schilling & Sons | 1126 E Monument |

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20369

## CERTIFICATE OF DEATH.

90 E 20369

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 806 N. Durham ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Ludwig (Ludwig)

(a) RESIDENCE No. 806 N. Durham ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? 51 yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Ludwig

6 DATE OF BIRTH (month, day, and year) Not known

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 77 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER John Ludwig

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Mary Ludwig (Address) 806 N. Durham St.

15 Filed 1 1927 C. HAMPSON JONES, M. D. Registrar Per RR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 17 1927

17 I HEREBY CERTIFY, That I attended deceased from 3-1, 1927, to 3-17, 1927, that I last saw h alive on 3-17, 1927, and that death occurred, on the date stated above, at 11.17 PM

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Findings

(Signed) J. Red Supplee M. D.

3-19-27 (Address) 810 N. Dall St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Mar 21 1927

20 UNDERTAKER Frank Crockson

ADDRESS 1916 Eutaw

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20370 E 20370

## CERTIFICATE OF DEATH.

135

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital ST. 13-52 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elijah Leach

(a) RESIDENCE NO. 3575 Cedar ave. ST., Hampden WARD
(Usual place of abode)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | white | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henrietta Leach

6 DATE OF BIRTH (month, day, and year) 1856

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 71 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Works in Cotton mills

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Oella Md

10 NAME OF FATHER Edwards Leach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Woodruff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Henrietta Leach
(Address) 3575 Cedar ave

Filed 2 1 1927. C. HAMPTON JONES, M. D.
Per Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-19 1927 7.15 am

17 I HEREBY CERTIFY, That I attended deceased from Mar 15 1927, to Mar 19 1927, that I last saw him alive on Mar 19 1927, and that death occurred, on the date stated above, at 7.15 am.

The CAUSE OF DEATH* was as follows:

HYPERTROPHY of PROSTATE
& RENAL INSUFFICIENCY

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Urinary Retention
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical & X-ray.

(Signed) Edwin [illegible], M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state 1) Means and Nature of Injury, and 2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem

DATE OF BURIAL March 24/27

20 UNDERTAKER Druid Ridge

ADDRESS Md

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20371

## CERTIFICATE OF DEATH.

90 E 20371

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1507 Ensor St ST., 9-18 WARD)

2-FULL NAME John F. Talbott.

(a) RESIDENCE No. 1507 Ensor st ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs mos ds. How long in U. S., if of foreign birth? life yrs mos ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, ~~or Divorced~~. (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Late Melissa Talbott.

6 DATE OF BIRTH (month, day, and year): Oct. 4. 1850

7 AGE: Years 76; Months 5; Days 15; If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Merchant.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

10 NAME OF FATHER: John Talbott.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Sarah Kilpatrick

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

PARENTS

14 Informant: Margaret Tabb.

(Address): 1507 Ensor St.

15 Filed 21 1927 C. HAMPTON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar. 19, 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar. 10, 1927, to Mar. 19, 1927, that I last saw him alive on Mar. 18, 1927 and that death occurred, on the date stated above, at 5 A. M.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical exam

(Signed) S. Lee Hagner, M. D.

3/19 19 (Address) 1206 E. Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery - March - 21 19 27

DATE OF BURIAL

20 UNDERTAKER: George - F. Ruth

ADDRESS: 1735 Harford ave.

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20372

## CERTIFICATE OF DEATH.

45 E 20372

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1704 Rutland St. 8th WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William E Conman

(a) RESIDENCE NO. 1704 Rutland ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie E Conman

6 DATE OF BIRTH (month, day, and year) Aug 29 1875

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 51 | 6 | 19 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Street Car Carder

(b) General nature of industry, business, or establishment in which employed (or employer) 078

(c) Name of employer Collier Co

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Geo Conman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Mary Durkee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Anna E Conman
(Address) 1704 N. Rutland ave

15 Filed MAR 21 1927 20 E. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr 1 1926 to Mar 18 1927.
that I last saw him alive on Mar 17 1927.
and that death occurred, on the date stated above, at 8.40 A m.
The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(duration) 2 yrs mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of Jan 1926

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) O H Cruikshank M. D.
Mar 18 1927 (Address) 3100 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore County — DATE OF BURIAL: March 21 1927

20 UNDERTAKER: George J. Ruth — ADDRESS: 1735 Harford

Spec.—1-12-23—M&T—500 Bks.

Salvino

# E 20373 HEALTH DEPARTMENT—CITY OF BALTIMORE

100-201

E 20373

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 414 N. Exeter St. ST., 5-8 WARD)

2-FULL NAME James . Salvino

(a) RESIDENCE NO. 414 N. Exeter St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Jan. 8/27

7 AGE: Years — Months 2 Days 10 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Michael Salvino

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy.

12 MAIDEN NAME OF MOTHER Josephine Zarogo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Michael Salvino

(Address) 414 N. Exeter st

15 Filed MAR 21 1927, 19 J. HAMPTON MOORE, M. D. Registrar

For —

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/18/1927

17 I HEREBY CERTIFY, That I attended deceased from March 11, 1927, to March 18 1927.

that I last saw h[illegible] alive on March 18 1927

and that death occurred, on the date stated above, at 11 P m

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) yrs. — mos 7 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Thomas J Ruth, M. D.

, 19 (Address) 632 E. Lemmon St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery

DATE OF BURIAL: March 21 1927

20 UNDERTAKER: George F. Ruth

ADDRESS: 1735 Harlford Ave

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

**E 20374**

## CERTIFICATE OF DEATH.

128 **E 20374**

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1316 N. Mount ST. 15-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Ball

(a) RESIDENCE NO. 1316 N. Mount ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | Married |

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mattie Ball

6 DATE OF BIRTH (month, day, and year) — — 1875

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 52 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Moluch Va

PARENTS

10 NAME OF FATHER Edward Ball

11 BIRTHPLACE OF FATHER (city or town) (State or country) Moluch Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown Unknown

14 Informant Ida Smith

(Address) 1507 N. Caroline St.

15 Filed 2-1-1927 C. HAMPSON JONES, M. D. Registrar

Per K.K.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17, 1927

17 I HEREBY CERTIFY, That I attended deceased from 2/14/ 1927 to March 17, 1927, that I last saw him alive on March 17th 1927, and that death occurred, on the date stated above, at 2:45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. 1 mos 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 1 mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of 3/14/27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Lee Elliott, M. D.

3/18, 1927 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Auburn — DATE OF BURIAL March 21 1927

20 UNDERTAKER Mrs. R. G. Elliott — ADDRESS 1720 Eastern Ave

Spec.—12-9-25—A Co.—200 Bks.

Lipscomb

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20375
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

48

E 20375
REGISTERED NO.

City of BALTIMORE: (No. Balto City Hospital 22-30 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Ernest Lipscomb

(a) RESIDENCE NO 626 W Baltimore St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | Col | Married. |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Estha Lipscomb

6 DATE OF BIRTH (month, day, and year) March 1884

| 7 AGE Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|
| 43 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va

(State or country)

PARENTS

10 NAME OF FATHER Orville Lipscomb

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Va Bowlow

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Estha Lipscomb

(Address) 626 W Barre st

15 Filed 2 1 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-16- 1927

17 I HEREBY CERTIFY, That I attended deceased from 1-29- 1927 to 3-16- 1927

that I last saw him alive on 3-16- 1927

and that death occurred, on the date stated above, at 4 45 a m.

The CAUSE OF DEATH* was as follows: Pneumonia Lobar

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Tumor Brain

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ernest Lipscomb M. D.

. 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Date of Burial March 29 27

20 UNDERTAKER J L Brown & Son ADDRESS 1018 W Mulberry

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 20376

## CERTIFICATE OF DEATH.

E 20376
REGISTERED NO.

1-PLACE OF DEATH Sinai Hospital

City of BALTIMORE: (No. ____ St. 27-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia B. Weisz

(a) RESIDENCE NO. 5220 Queensbury Ave St. ____ Ward ____

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. 7 mos. 17 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | W | — |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 3 - 1921

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 5 | 7 | 17 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ....

(b) General nature of industry, business, or establishment in which employed (or employer) ....

(c) Name of employer

9 BIRTHPLACE (city or town) Balto City

(State or country) Md

PARENTS

10 NAME OF FATHER Albert B Weisz

11 BIRTHPLACE OF FATHER (city or town) ....

(State or country) Hungary

12 MAIDEN NAME OF MOTHER Rose Berman

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Md

14

Informant Rose Weisz

(Address) 5220 Queensbury Ave

15 Filed ____ C. HAMPSON JONES, M. D. Registrar

Per ____

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 1927

17

I HEREBY CERTIFY, That I attended deceased from March 16, 1927, to March 20, 1927, that I last saw her alive on March 20, 1927, and that death occurred, on the date stated above, at 7:20 p. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia bilateral

(duration) ... yrs. ... mos. 16 ds.

CONTRIBUTORY (Secondary) Acute empyema
Cardiac failure

(duration) ... yrs. ... mos. 4 ds.

Is Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Mar. 11. 1927

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Max Mansfeld, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Hebrew Friendship Cem | 3/22 19 27 |
| 20 UNDERTAKER | ADDRESS |
| Jack Lewis | 1439 E Balto St |

Spec.—12-9-25—A Co.—200 Bks.

É 20377

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

É 20377

REGISTERED NO. _____

1-PLACE OF DEATH Mercy Hospital

City of BALTIMORE: (No. _____ St., 15-68 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Gartside

(a) RESIDENCE NO. 1801 N. Swallwood St, St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W 1

5 Single, Married, Widowed, or Divorced. (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1867

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 60, | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter

(b) General nature of industry, business, or establishment in which employed (or employer): O.S.

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Maryland

PARENTS

10 NAME OF FATHER Chas Gartside

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Adaline Fisher

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Maryland

14 Informant Mercy Hospital

(Address) N. Calvert St.

15 Filed MAR 21 1927 C. HAMPSON JONES, M. D. Registrar

By _____

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 16, 1927, to March 19, 1927, that I last saw h[illegible] alive on March 19, 1927, and that death occurred, on the date stated above, at 12 N. m.

The CAUSE OF DEATH* was as follows:

acute nephritis • Uremia

Infected foot + Septicemia, over

(duration) yrs. mos. ds.

CONTRIBUTORY _____

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death!

Did an operation precede death! yes Date of Feb 24-1927

Was there an autopsy! Yes Pneumonia + diabetes Found

What test confirmed diagnosis! _____

(Signed) H Wells, M. D.

, 19 (Address) Mercy Hos

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn — Date of Burial: Mar 22 1927

20 UNDERTAKER: Josiah Lefler — ADDRESS: 1600 W North Ave

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 20378 — REGISTERED NO. E 20378

1-PLACE OF DEATH St Josephs Hospital

CITY OF BALTIMORE: (No.) Caroline & Oliver St. 1-24 (Ward) 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George L. Berry

(a) RESIDENCE NO. 1232 Ettinger St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Negro. | married. |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Josephine M. Berry

6 DATE OF BIRTH (month, day, and year): Aug. 6- 1866

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 60 | 7 | 12 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Janitor

(b) General nature of industry, business, or establishment in which employed (or employer): Masonic Temple

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: London Berry

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Maria Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Charles L. Berry (Bro)

(Address): 622 George St.

15 Filed MAR 21 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 23, 1927, to March 18, 1927, that I last saw him alive on March 18, 1927, and that death occurred, on the date stated above, at 3:35 a.m.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis. Myocarditis.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Bronchial Pneumonia

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? No Date of

Was there an autopsy? None.

What test confirmed diagnosis? Clinical

(Signed) Grant R. Desaulles, M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: Mar. 21 1927

20 UNDERTAKER: Jno. W. Johnson — ADDRESS: 1234 Ettinger St.

Cor.—12-9-25—A Co.—200 Bks.

20379

# HEALTH DEPARTMENT—CITY OF BALTIMORE

74-221 E 20379

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. Gen. Hosp. St. N-69 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H. Shuppner

(a) RESIDENCE NO. 2534 Wilkens Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. da.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Evelyn C. Shuppner

6 DATE OF BIRTH (month, day, and year) Jan. 28, 1883

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 44 | 1 | 21 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher

(b) General nature of industry, business, or establishment in which employed (or employer) Beef.

(c) Name of employer Self.

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER Geo. Shuppner

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Annie Roldy

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Evelyn C. Shuppner

(Address) 2534 Wilkens Ave.

15 Filed Mar 21 1927 C. HAMPSON JONES, M. D.

Per RR Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) no other history

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D. (Coroner)

1927 (Address) March 20, 2802 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Date of Burial March 22 1927

20 UNDERTAKER H. A. Little ADDRESS 2703 Edmondson Ave

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

178

É 20380

É 20380

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2035 McCulloh St. St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laura V. Belt

(a) RESIDENCE NO. 2035 McCulloh St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Simon Belt

6 DATE OF BIRTH (month, day, and year): about 1872

7 AGE: Years 55 Months Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of Indnstry, business, or establishment in which employed (or employer): 070

(c) Name of employer

9 BIRTHPLACE (city or town): Md.

(State or country)

PARENTS

10 NAME OF FATHER: Frederick Smith

11 BIRTHPLACE OF FATHER (city or town): Md.

(State or country)

12 MAIDEN NAME OF MOTHER: Laura Smith

13 BIRTHPLACE OF MOTHER (city or town): Va.

(State or country)

14 Informant: Nelson White

(Address): 2035 McCulloh St

16 Filed 2-21 1927 C. HAMPSON JONES, M. D. *Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 15, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

3rd degree burns of body (accidental) five minutes

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) coal gas (Leaking gas pipes near stove)

(duration) yrs. mos. ds.

(Signed) Dr. T. Hennessy M.D.

(Coroner)

1927 (Address) 280 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery Date of Burial 3/2/ 1927

20 UNDERTAKER: Mrs Chas G. Bailey ADDRESS 1421 Jefferson St

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20381

CERTIFICATE OF DEATH

73 E 20381

1-PLACE OF DEATH Josephine E. Schwarzkopf

City of BALTIMORE: (No. Sinai Hospital St., 27-41 Ward)

REGISTERED NO. _____

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Josephine E. Schwarzkopf

(a) RESIDENCE NO. 3018 Parkside Drive Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred 64 yrs. 9 mos. 17 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced (~~HUSBAND~~ of) (or) WIFE of: Lieut. Henry A. Schwarzkopf

6 DATE OF BIRTH (month, day, and year): June 3 1862

7 AGE

| Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|
| 64 | 9 | 17 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto., Md

(State or country)

PARENTS

10 NAME OF FATHER: Frank Fohner

11 BIRTHPLACE OF FATHER (city or town): Germany

(State or country)

12 MAIDEN NAME OF MOTHER: Sophia Lucke

13 BIRTHPLACE OF MOTHER (city or town): Germany

(State or country)

14 Informant: Lieut. Henry A. Schwarzkopf

(Address) 3018 Parkside Drive

15 Filed _____ 19 _____ C. HAMPSON JONES, M. D. Registrar

MAR 21 1927

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

3-20-27

17

I HEREBY CERTIFY, That I attended deceased from 3-16, 1927, to 3-20, 1927, that I last saw her alive on 3-20, 1927, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Cardiac failure.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Hypertension - Arteriosclerosis - Bulbar Paralysis (Sclerosis)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Max H. Rosenfeld, M. D.

, 19 (Address) Sinai Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery Date of Burial: March 23 1927

20 UNDERTAKER: D. Henry Hoeck Son ADDRESS: 130 E Eager St

Fee $1.00

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20382

## CERTIFICATE OF DEATH.

101-001 L

E 20382

REGISTERED NO.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St., 4-46 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martin Kirby

(a) RESIDENCE NO. 1756 Gorsuch St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widower |

5a If married, widowed or divorced HUSBAND of (or ~~WIFE~~) of Mary E. Kirby

6 DATE OF BIRTH (month, day, and year) 1842

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 85 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Pat. Kirby

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant

(Address) Records

MAR 21 1927

HAMPSON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 1927

17

I HEREBY CERTIFY, That I attended deceased from February 28, 1927, to March 20, 1927, that I last saw him alive on March 19, 1927, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) .....yrs. .....mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? No.

What test confirmed diagnosis? Journal & Laboratory

(Signed) R. Hobpe Limtl, M. D.

Md 20 1927 (Address)

BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery Date of Burial Mard 22 1927

20 UNDERTAKER Henry Hook Son ADDRESS 130 E Eager St

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

É 20383

## CERTIFICATE OF DEATH.

É 20383

1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home & Infirmary St. Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Matilda Schmidt

(a) RESIDENCE NO. 427 S. Mount St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mendelin Schmidt

6 DATE OF BIRTH (month, day, and year): May 15 1890

7 AGE

| Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|
| 36 | 10 | 5 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer

9 BIRTHPLACE (city or town): Balto.

(State or country): Md.

PARENTS

10 NAME OF FATHER: Wilhelm Ringius

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Eliza Rachuy

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Germany

14 Informant: Mendelina Schmidt

(Address) 427 S. Mount St.

15 Filed MAR 21 1927

C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

March 20, 1927

17 I HEREBY CERTIFY, That I attended deceased from March 11, 1927 to March 20, 1927, that I last saw h.. alive on March 20, 1927, and that death occurred, on the date stated above, at 12:30 A m.

The CAUSE OF DEATH* was as follows:

Acute Ulcerative Cystitis

Acute Nephritis

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 6 ds.

Is Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Vernon H. Mowat M. D.

Mar 20, 1927 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery Mar. 23 19 27

20 UNDERTAKER: George L. Schwaab ADDRESS 2101 Eutaw

Spec.—8-24-14—M. & T.—2000 Bks.

Marie L Koch.

E 20384

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 20384

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 8 Tremont Ave. 26 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. L. Koch

(Residence in Baltimore: No. 8 Tremont Ave St.; Life yrs. mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, or DIVORCED (write the word.): Single

6-DATE OF BIRTH: Dec. 12, 1904 (Month) (Day) (Year)

7-AGE, 22 yrs. 3 mos. 6 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Sales Lady
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER: Martin Koch

11-BIRTHPLACE OF FATHER (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Kathryn E. Stiegler

13-BIRTHPLACE OF MOTHER (State or Country): Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martin Koch

(Address) 8 Tremont Road

15-

Filed ....., 191.....

Per ..... Registrar.

C. HAMPSON JONES, M. D.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 18, 1927 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 27 1926, to March 18 1927, that I saw h-d alive on March 17 1927, and that death occurred, on the date stated above, at 8a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Endocarditis Pulmonary

Ordered (Duration) yrs. mos. 3 ds.

(Signed) Norbert L. Hegel M. D.

March 19, 1927 (Address) 215 N. Wolfe St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery DATE OF BURIAL, Mar. 21, 1927

20-UNDERTAKER George L. Schwab ADDRESS 1101 Eutaw St.

MAR 21 1927

Spec.–7-17-26—A Co.—200 Bks.

2a Congdon Roland Ave & 8th St ✓

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

84

É 20385 — REGISTERED NO. É 20385

1-PLACE OF DEATH

City of BALTIMORE: (No.) 200 Wyndhurst Ave (St.) 27-53 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Granville C Wilson

(a) RESIDENCE NO. 200 Wyndhurst Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Amelia Wilson

6 DATE OF BIRTH (month, day, and year): Jan - 27 - 1831

7 AGE — Years: 96 Months: 1 Days: 23 IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Merchant, Retired

(b) General nature of industry, business, or establishment in which employed (or employer): 45

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Mass

PARENTS

10 NAME OF FATHER: Elipholet Wilson

11 BIRTHPLACE OF FATHER (City or town) (State or country): Mass

12 MAIDEN NAME OF MOTHER: Amelia Rondall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Mass

14 Informant: Amelia Wilson (Address) 200 Wyndhurst Ave

15 Filed MAR 31 1927 C. HAMPSON JONES, M. D. Registrar

Per RR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 20 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 1, 1927, to Mar 21, 1927, that I last saw h[illegible] alive on March 21, 1927, and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Cerebral Pressure

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia - Senility

(duration) yrs. mos. 21 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Symptoms

(Signed) C Tilden Davis M. D.

3/21 1927 (Address) 37.1 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Prospect Hill, Towson Md — Date of Burial: Mar 22 1927

20 UNDERTAKER: H. M. Cook — ADDRESS: 502 E Monument

Spec. 1-10-21—M&T—1500 Bks.

# É 20386 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

É 20386
REGISTERED NO.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. Woodland Ave & Reisterstown Rd. ST. 27-55 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Talley

(a) RESIDENCE No. Woodland Ave & Reisterstown Rd. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.
4 COLOR OR RACE: W.
5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word): M.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jesse Talley

6 DATE OF BIRTH (month, day, and year): Nov 9. 1870

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 57 | 0 | 10 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Home Duties
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (City or town) (State or country): Miss

PARENTS
10 NAME OF FATHER: Wyatt E. Nelson
11 BIRTHPLACE OF FATHER (city or town) (State or country): Penn
12 MAIDEN NAME OF MOTHER: Whitmore
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Jesse Talley
(Address) Woodland Ave & Reisterstown Rd.

15 Filed MAR 2 1927, 19.. C. HAMPSON JONES, M. D. Registrar
Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/19/1927

17 I HEREBY CERTIFY, That I attended deceased from 3-12-1927 to 3-19-1927 that I last saw h alive on 3-19-1927 and that death occurred, on the date stated above, at 11.55 P m.

The CAUSE OF DEATH* was as follows:
Influenza.
(duration) yrs. mos. 5 ds.
CONTRIBUTORY (Secondary) Bronchio Pneumonia
(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Meredith Lowell M. D.
3/19, 1927 (Address) 3705 Liberty Hts Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount, Lafox
DATE OF BURIAL: Mar 21 1927

20 UNDERTAKER: W. H. Cook
ADDRESS: 507 E. Lanvale St.

Spec.—12-9-25—A Co.—200 Bks.

Letter on file from R Hooper Smith MD dated April 2-1927

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20387

X 100-00

E 20387

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

REGISTERED NO. 27-56

City of BALTIMORE: (No. [redacted] St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Williams

(a) RESIDENCE NO. 115 Woodlawn Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. 7 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Margaret E. Williams

6 DATE OF BIRTH (month, day, and year) 1852 May 12 1859

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| 68 | ~~75~~ | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Delaware

PARENTS

10 NAME OF FATHER Joseph Williams

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliza –

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Delaware

14 Informant BALTIMORE CITY HOSPITALS

(Address) [redacted] Ward

15 Filed MAR 21 1927 HAMPSON JONES M D Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 1927

17 I HEREBY CERTIFY, That I attended deceased from March 15 1927, to March 20, 1927, that I last saw h[illegible] alive on March 19, 1927, and that death occurred, on the date stated above, at 3 40 A m.

The CAUSE OF DEATH* was as follows:

Erythrema Multiforme

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? General & Laboratory

(Signed) R Hooper Smith, M. D.

March 20 1927 BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Seaford Delaware Date of Burial 3/22 1927

20 UNDERTAKER Wm Cook ADDRESS 502 E Main

Spec.–7-17-26—A Co.—200 Bks.

E 20388

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

21 E 20388

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 819 S Belnord Ave St. 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johanna Tanski

(a) RESIDENCE NO. ~~819 S Belnord Ave~~ 6218 Wolfe st St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? 13 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anthony J Tanski

6 DATE OF BIRTH (month, day, and year) June 13 1902

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..hrs. or ..min.. |
|---|---|---|---|---|
| | 24 | 9 | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Housework 037

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Poland

PARENTS

10 NAME OF FATHER John Antkowiak

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Pelagia Antkowiak

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant John Antkowiak

(Address) 819 S Belnord Ave

Filed MAR 21 1927 E. HAMPSON JONES M. D. City Registrar

Per RM

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 1927

17 I HEREBY CERTIFY, That I attended deceased from March 18 19 27 to March 19 19 27

that I last saw her alive on March 19 19 27

and that death occurred, on the date stated above, at 4 00 p.m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Diabetes Insipidus

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas L Johnson M. D.

(Address) 30 S Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus March 22 1927

Date of Burial

20 UNDERTAKER John M Weber

ADDRESS 1503 Bank St

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20389

## CERTIFICATE OF DEATH.

90

REGISTERED E 20389

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1720 Shroeder Court ST. 17-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Karasinski

(a) RESIDENCE No. 1720 Shroeder Court ST. WARD

(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 90 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Karasinski

6 DATE OF BIRTH (month, day, and year) 1857

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs. or min. |
|---|---|---|---|---|
| | 70 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer odd

(b) General nature of industry, business, or establishment in which employed (or employer) Shrewsbury

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Andrew Karasinski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mary Karasinski

(Address) 1720 Shroeder Court

15 Filed 2-1-1927, 19 C. HAMPSON JONES, M. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 1927

17 I HEREBY CERTIFY, That I attended deceased from January 29, 1927, to March 16, 1927, that I last saw him alive on March 16, 1927, and that death occurred, on the date stated above, at 5-10 a. m.

The CAUSE OF DEATH* was as follows:

1 Bronchitis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Mitro Regurgitation

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Cardiac trouble

(Signed) E. P. Donaldson Jr. M. D.

3-6-1927 (Address) 2042 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus DATE OF BURIAL: March 23 1927

20 UNDERTAKER: John M Weber ADDRESS: 1803 Bank St

Spec.—7-17-26—A Co.—200 Bks.

20390

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

11-001

REGISTERED NO. E 20390

1-PLACE OF DEATH

City of BALTIMORE: (No. 513 Radnor Ave St. 2748 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva Baginska

(a) RESIDENCE NO. 513 Radnor Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 29 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? 29 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1862

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|---|
| | 65 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 07

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Poland

PARENTS

10 NAME OF FATHER Michael Lewandowski

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Klimenty Lewandowski

(Address) 513 Radnor Ave

Filed MAR 27 1927 G. HAMPSON JONES, M. D. Registrar

By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

March 18 1927

17 I HEREBY CERTIFY, That I attended deceased from March 7, 19 27, to March 18, 19 27, that I last saw h.. alive on March 18, 19 27, and that death occurred, on the date stated above, at 320 p m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? None

(Signed) Thos. A. Stevens, M. D.

3/20. 1927 (Address) 2478 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Date of Burial March 22 1927

20 UNDERTAKER John M. Weber ADDRESS 1803 Bank

Be sure to be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20391

## CERTIFICATE OF DEATH

129 E 20391

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 502 E Clement St. 24-33 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Vogelgesang.

(a) RESIDENCE NO. 502 E Clement St. 24 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. 7 mos. 17 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widower |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Vogelgesang.

6 DATE OF BIRTH (month, day, and year) August 2nd 1859

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min.. |
|---|---|---|---|---|
| | 67 | 7 | 17 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Marine Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.

(State or country)

PARENTS

10 NAME OF FATHER Henry Vogelgesang.

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany.

14 Informant Mrs. Charles Schnirrer

(Address) 423 E Clement St

15 Filed MAR 1 1927 19 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14th 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 1 1927 to Mar 14 1927 that I last saw him alive on Mar 16 1927 and that death occurred, on the date stated above, at 12 30 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema & Cardiac Dilatation

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) F. F. Hawkins, M. D.

3/30, 1927 (Address) 16 Randall St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Cedar Hill. | 3-22 1927 |

20 UNDERTAKER A. B. Harle ADDRESS 115 E. West St

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

58-001

E 20392

## CERTIFICATE OF DEATH

E 20392
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1120 Eight St Ward) Mount Park 25

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary J Koenig.

(a) RESIDENCE NO. 1120 Eight St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Frederick N. Koenig

6 DATE OF BIRTH (month, day, and year) January 24 1870

| 7 AGE | Years | Months | Days |
|---|---|---|---|
| | 57 | 1 | 23 |

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Germany.

PARENTS

10 NAME OF FATHER August Kummer

11 BIRTHPLACE OF FATHER (City or town)
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Johanna Koch.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany.

14 Informant Charles Koenig.
(Address) 1135 Union Ave.

15 Filed MAR 2 1927 19 HAMPSON JONES, M. D. Registrar
Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19th 19 27

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1926, to March 18, 1927, that I last saw h.. alive on March 18, 1927, and that death occurred, on the date stated above, at 6 15 A m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(duration) yrs. 8 mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Blood Count

(Signed) Lamard C Beach M. D.

. 19 (Address) 2229 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — Date of Burial 3-22 19 27

20 UNDERTAKER Mr. Chas A G Rohde — ADDRESS 600 Washington Ave

Very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

99256

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

20393 E OF DEATH

E 20393
REGISTERED NO.

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Tillie Pisarek

(a) RESIDENCE NO. North Point Rd St. Colgate Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 Color or Race: White
5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of: Capitano Pisarek

6 DATE OF BIRTH (month, day, and year): 1887

| 7 AGE | Years | Months | Days | IF LESS than 1 day ...hrs. or ...min. |
|---|---|---|---|---|
| | 40 | 2 | — | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9 BIRTHPLACE (city or town)
(State or country): Poland

PARENTS

10 NAME OF FATHER: —

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Poland

12 MAIDEN NAME OF MOTHER: —

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Poland

14 Informant: Records
(Address): Johns Hopkins Hospital

15 Filed MAR 21 1927, 19 C. HAMPSON JONES, M. D. Registrar
Per RM

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 19, 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 14, 1927, to March 19, 1927, that I last saw her alive on March 19, 1927, and that death occurred, on the date stated above, at 11.45 p m.

The CAUSE OF DEATH* was as follows:
Cardio-Vascular disease with Uraemia

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary): —
(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) C. Hampson Jones, M. D.
, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount — Date of Burial: March 24 1927

20 UNDERTAKER: George A. Weber — ADDRESS: 2205 Eutaw St.

Spec.—1-10-21—M&T—1500 Bks.

E 20394

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20394

## CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 238 Colvin St. 5-8 WARD)

2-FULL NAME Annie Roy

(a) RESIDENCE NO. 238 Colvin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Tom Roy.

6 DATE OF BIRTH (month, day, and year): 1858 ~~not known~~

7 AGE: Years 69 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Prince Georges Co. Maryland

PARENTS

10 NAME OF FATHER: Daniel Roy

11 BIRTHPLACE OF FATHER (city or town) (State or country): not known

12 MAIDEN NAME OF MOTHER: not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): not known

14 Informant: Elizabeth Coleman

(Address) 238 Colvin St.

15 Filed 4 1927 19 Per C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 28 1927 to March 18 1927.

that I last saw her alive on March 18 1927,

and that death occurred, on the date stated above, at 2.20 p. m.

The CAUSE OF DEATH* was as follows:

C. Myocarditis

(duration) Two yrs. mos ds.

CONTRIBUTORY (Secondary): Nephritis.

(duration) yrs. Six mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical & Symptoms

(Signed) John E. F. Campbell M. D.

19 (Address) 1400 N. Mount

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: 3/21 1927

20 UNDERTAKER: Samuel J. Crowley

ADDRESS: W. Balto

THIS IS very important See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 20395

# HEALTH DEPARTMENT—CITY OF BALTIMORE

11-002

E 20395

## CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1846 Spring St. 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Salvadera

(a) RESIDENCE NO. 1846 N. Spring St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE: Years 51 Months Days IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Govanstown

(State or country) Md.

PARENTS

10 NAME OF FATHER Samuel Garrett

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Fannie Slaughter

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Adolphus Garrett

(Address) 401 Schaub Ave.

15 Filed MAR 21 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18 1927

17 I HEREBY CERTIFY, That I attended deceased from March 14, 1927, to March 17, 1927, that I last saw her alive on March 17, 1927, and that death occurred, on the date stated above, at 5-a m.

The CAUSE OF DEATH was as follows:

Influenza

(duration) yrs. mos 21 da.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Evidence

(Signed) Garland Thomas M. D.

March 21 1927 (Address) 1534 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Zion Cem. Date of Burial 3/20 27

20 UNDERTAKER: Samuel F. Brumley ADDRESS 1778 Bolton St

Very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

20396

## CERTIFICATE OF DEATH.

45 E 20396

1-PLACE OF DEATH Maryland General Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 15-28 ST. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Frank Lauber

(a) RESIDENCE NO. 1733 Braddish St Ave WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lily C Lauber

6 DATE OF BIRTH (month, day, and year) Feb 13, 1888

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| 29 | 49 | 1 | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Auto Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Frank Lauber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Emma Huckleman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Hospt Records (Address)

15 Filed MAR 21 1927 C. HAMPSON JONES, M. D. Registrar. By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar. 3, 1927, to Mar 19, 1927, that I last saw h/M alive on Mar 19, 1927, and that death occurred, on the date stated above, at 4 20 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cecum

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Tobacco

(duration) yrs. mos. 5 ds.

18 Where was disease contracted If not at place of death? At home

Did an operation precede death? yes Date of 3-3-27

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno A Tompkins M. D.

, 19 (Address) 1111 Gardenia

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem DATE OF BURIAL March 21 1927

20 UNDERTAKER D. M. Rountree ADDRESS 2238 W Mulb

Spec.—12-9-25—A Co.—200 Bks.

E 20397

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

X 100-001

E 20397

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 630 Lemmon St. 16-67 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Erastus Sevilious Brown

(a) RESIDENCE NO. Lodge, Va St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 3 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | Single |

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Roveller Coolyman Brown

6 DATE OF BIRTH (month, day, and year) Oct 10 1862

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 64 | 5 | 9 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Hainesville

(State or country) Va

PARENTS

10 NAME OF FATHER Rubin Brown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Mary Lewis

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va Howard

14 Informant Erastus Brown (son)

(Address) 630 Lemmon St

15 Filed 1927 19 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Mar 19 - 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 8th, 1927, to Mar 18th, 1927, that I last saw him alive on Mar 18th, 1927, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Lee Broncho-pneumonia

(duration) — yrs. — mos. 10 ds.

CONTRIBITORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) H. R. Keener, M. D.

3/19 1927 (Address) 3431 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lodge Va. Date of Burial 3/22. 1927

20 UNDERTAKER Fredk. A. Cole ADDRESS 1411 Hollins St.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

49 E 20398

**E 20398**

## CERTIFICATE OF DEATH

REGISTERED NO. 13-54

1-PLACE OF DEATH

City of BALTIMORE: (No. 2548 Frances St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Kellen

(a) RESIDENCE NO. 2548 Frances St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 5 mos. 22 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) September 27th 1864

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min.. |
|---|---|---|---|---|
| | 62 63 | 5 | 22 21 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Dry Goods

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER John Kellen

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Rachel A. Johnston

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Wm. Johnston

(Address) 2548 Frances St.

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

Per .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927

March 18th.

17 I HEREBY CERTIFY, That I attended deceased from May 10th, 1926, to March 18th, 1927, that I last saw her alive on March 18th, 1927, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Uremia, due to Ovarian cancer absorption from metastasis of Bladder

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Bladder

(duration) yrs. mos. ds.

18 Where was disease contracted Unknown.

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? None obtained

What test confirmed diagnosis? Cystoscope.

(Signed) Amelia E. Zimmerman, M. D.

, 19 - (Address) 1805 W North ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Loudon Park Cemetery | March 21 1927 |

20 UNDERTAKER Robt. F. Turner ADDRESS 1442 N Broadway Baltimore, Md.

APR 1927

Very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

McGabb.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E-20399

38 E 20399

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat St. 28-63 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosetta McCobb

(a) RESIDENCE NO. Mt Hope Retreat ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 52 | Unknown | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Steven Hellsinger

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) New York State

12 MAIDEN NAME OF MOTHER Sarah McKinney

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Maryland

14 Informant Mt Hope Friends

(Address)

15 Filed MAR 21 1927 C. HAMILTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20, 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 7, 1925, to March 20, 1927, that I last saw h[illegible] alive on March 20, 1927, and that death occurred, on the date stated above, at 4.15 P. m.

The CAUSE OF DEATH* was as follows:

Paresis

(Cerebral Syphilis)

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Septicaemia

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Serological

(Signed) Milton P. Dill, M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Johns Cem. DATE OF BURIAL Mar 23 1927

UNDERTAKER Easton Sons ADDRESS Ellicott City

Spec.—1-12-23—M&T—Sx. Bks.

E 20400

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

10-E 20400

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4100 Woodbine Ave ST. 28-63 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellsworth Burnett Stehley

(a) RESIDENCE No. 4100 Woodbine Ave ST., ..... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. 5 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 25 1918

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or ..... min. |
|---|---|---|---|---|
| | 8 | 5 | 23 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER A Ellsworth Stehley

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Nettie M Towner

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Md

14 Informant A Ellsworth Stehley
(Address) 4100 Woodbine Ave

15 Filed 3 21 1927 19 C. HAMILTON JONES, M. D. Registrar
Per R H

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-20 - 1927

17

I HEREBY CERTIFY, That I attended deceased from March 10, 1927, to March 20, 1927, that I last saw him alive on 3-20 - , 1927, and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH was as follows:

Diphtheria.

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A Ellsworth Lord M. D.

, 19 (Address) 3705 Liberty Hgts. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL Mar 21 1927

UNDERTAKER Harry A Amacker — ADDRESS 4204 Ridgewood Ave

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 20401 — REGISTERED E 20401

X 118-002

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herbert E. Lasche

(a) RESIDENCE NO. 695 Farwell Ave. Milwaukee Wis.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jennie Lau Roo Lasche

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years 56 | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Insurance

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Manitowoc Wis.

(State or country)

PARENTS

10 NAME OF FATHER: Julius Lasche

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Wis

12 MAIDEN NAME OF MOTHER: Henschman

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Wis.

14 Informant: Dr. Theodore G. Lasche

(Address): Johns Hopkins Hospital

15 Filed [illegible] 1927 HAMILTON JONES, M. D. Registrar

MAR 21 1927 Per [illegible]

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar. 21- 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 11 1927, to Mar 21- 1927, that I last saw him alive on Mar 21- 1927, and that death occurred, on the date stated above, at 12 [illegible] A.M.

The CAUSE OF DEATH* was as follows:

Paralytic ileus

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 3/17/27.

Was there an autopsy? yes.

What test confirmed diagnosis? Clinical & autopsy

(Signed) W. Lindsay Keller M. D.

3/21/1927 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Milwaukee Wis Date of Burial Mch 22 1927

20 UNDERTAKER: John O. Mitchell ADDRESS 1924 Eastlawn Place

Spec—12-23-21—E.B.R.S.—400 Bks.

Brunings

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20402

1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

13-5990 E 20402

Registered No.

City of BALTIMORE: (No. 2254 Brookfield Ave St.) Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pauline Brumings

(a) Residence No. 2254 Brookfield Ave St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced, (Write the word.): Widowed

5a-If married, widowed, or divorced WIFE of Edmund Brunings

6-DATE OF BIRTH (month, day and year) Oct. 19. 1864

7-AGE: 62 yrs. 5 mos. 0 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Cord Gustavus

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Johanne Klocketer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-

(Informant) Paula M. Gustavus

(Address) 2037 Mondawmin Ave.

15-

Filed OCT 1927 C. HAMPSON JONES, M. D. Registrar.

Per

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 19. 1927

17- I HEREBY CERTIFY, That I attended deceased from Feb. 15. 1927 to Mar. 19 1927

that I last saw her alive on Mar. 18 1927

and that death occurred, on the date stated above, at 2:15 P m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(Duration) yrs. 1 mos. ds

CONTRIBUTORY (Secondary) Myocarditis.

(Duration) yrs. 6 mos. ds

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Thos. C. Blake M. D.

, 19 (Address) 1014 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cemetery — DATE OF BURIAL: March 22 1927

20-UNDERTAKER: Hughes & Lee — ADDRESS: 1104 N. Broadway

Spec—12-23-21—E.B.R.S.—400 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20403

1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

12 E 20403

Registered No.

City of BALTIMORE: (No. 1912 E. Federal St. St., 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alverta Peed

(a) Residence No. 1912 E. Federal St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, ~~widowed, divorced~~ HUSBAND ~~OR WIFE~~ of Harry Peed

6-DATE OF BIRTH (month, day and year) Dec. 24. 1884

7-AGE. 42 yrs. 2 mos. 23 ds. 25

If LESS than 1 day, ....hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: house work

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer:

9-BIRTHPLACE (city or town) Baltimore (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Courtney

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Johanna Hatton

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country), Maryland

11- (Informant) Harry Peed

(Address) 1912 E. Federal St.

15- Filed MAR 21 1927 H. HAMILTON JONES, M. D. Registrar.

Per

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 19. 1927

17- I HEREBY CERTIFY, That I attended deceased from March 17 1927 to March 19. 1927

that I last saw her alive on March 18 1927

and that death occurred, on the date stated above, at 5:30A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
Arterial hypertension

(Duration) 1 yr.

CONTRIBUTORY (Secondary) Apoplexy

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Physical Examination

(Signed) Albert Greenberg M. D.

3/30/ 1927 (Address) 707 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19-PLACE OF BURIAL, CREMATION OR REMOVAL. | DATE OF BURIAL. |
|---|---|
| Baltimore Cemetery | March 22, 1927 |
| 20-UNDERTAKER. | ADDRESS |
| Stephen J. Lonedale | 434 N. Broadway |

Spec.—1-12-23—M&T—500 Blks.

E 20404

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 20404

105001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital St. 20-70 WARD)

2-FULL NAME Patrick Kohlenberg

(a) RESIDENCE NO. 3110 Strickland ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3-17-26

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 1 | | 2 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Wm. Kohlenberg

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) not given Md.

12 MAIDEN NAME OF MOTHER Helen M. Caplkin

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) " Md.

14 Informant Wm. Kohlenberg
(Address) 3110 Strickland

15 Filed 2-1 1927. 19 C. HAMPSON JONES, M. D.
Per Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-19 1927

17

I HEREBY CERTIFY, That I attended deceased from 2-26, 1927, to 3-19, 1927, that I last saw h[illegible] alive on 3-19, 1927, and that death occurred, on the date stated above, at 5 20 P m.

The CAUSE OF DEATH* was as follows:

EMPYEMA FOLLOWING LOBAR PNEUMONIA

(duration) yrs. mos. 23 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? YES

Did an operation precede death? [illegible] Date of 2-28-27.

Was there an autopsy? NO

What test confirmed diagnosis? PHYSICAL EXAM.

(Signed) WP Hampson M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery DATE OF BURIAL 3-22-27

20 UNDERTAKER Martin Fahey Sons ADDRESS 1827 N Smith Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

E 20405 HEALTH DEPARTMENT—CITY OF BALTIMORE E 20405

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1926 E Balto St. St., 6-9 Ward) 100-001

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Elanor Dolitz

(a) Residence No. 1926 E Baltimore St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

| 3-SEX. | 4-COLOR OR RACE, | 5-Single, Married, Widowed, or Divorced, (Write the word.) |
|---|---|---|
| Female | white | S |

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Jan. 10, 1925

7-AGE. yrs. 2 mos. 11 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md.

PARENTS.

10-NAME OF FATHER, James Dolitz

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Elanora Dugan

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country), Md

14- (Informant).

(Address).

15- Filed 1927 C. HAMPSON JONES, M. D. Registrar.

Ref 1161

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 21, 1927

17- I HEREBY CERTIFY, That I attended deceased from March 18, 1927 to March 21 1927 that I last saw h.r alive on March 21 1927 and that death occurred, on the date stated above, at 12.30 p.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Robt. Isaacs M. D.

, 19 (Address) 1827 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.) 1927

19-PLACE OF BURIAL, CREMATION OR REMOVAL. HOPKINS HOSPITAL DATE OF BURIAL. , 19

20-UNDERTAKER. Health Commissioner ADDRESS

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001

Ė 20406

## CERTIFICATE OF DEATH.

Ė 20406

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE; (No. Johns Hopkins Hospital. St. 17-25 Ward)

2-FULL NAME Baby Barrett

(a) RESIDENCE NO. 626 W Madison St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Black

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Mar. 17, 1927

| 7 AGE | Years | Months | Days | IF LESS than 1 day 6 hrs. or ___ min. |
|---|---|---|---|---|
| | | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 0

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): _____

(State or country): Md.

PARENTS

10 NAME OF FATHER: Earnest Barrett

11 BIRTHPLACE OF FATHER (city or town): _____

(State or country): U. S.

12 MAIDEN NAME OF MOTHER: Mildred Williams

13 BIRTHPLACE OF MOTHER (city or town): _____

(State or country): U. S.

14 Informant: J K Boerner MD

(Address): Johns Hopkins Hospital.

15 Filed _____ 19___ C. HAMPSON JONES, M. D. Registrar

MAR 1927 14 25 APR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar. 17 19 27

17

I HEREBY CERTIFY, That I attended deceased from 3-17, 1927, to 3-17, 1927, that I last saw h__ alive on 3-17, 1927, and that death occurred, on the date stated above, at 9:50 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

_____ (duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary)

_____ (duration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ___ Date of ___

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J K Boerner, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: _____ Date of Burial: MAR 21 1927 19

20 UNDERTAKER: _____ ADDRESS: _____

JOHNS HOPKINS HOSPITAL

Commissioner Health.

Per. Wm. E. Fondal

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20407

E 20407

## CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH St. Agnes. Hospital

CITY OF BALTIMORE: (No.) St. Agnes Hospital (ST., AGNES WARD) 5.C. 14-28

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. George Johnson.

(a) RESIDENCE NO. 217 S. Gilmor ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, (Married,) Widowed, or Divorced, (write the word) |
|---|---|---|
| Male. | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Johnson. Daisy.

6 DATE OF BIRTH (month, day, and year) July 29 1879

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| 5= | 47 | 7 | 20 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman 086

(b) General nature of industry, business, or establishment in which employed (or employer) Foreman

(c) Name of employer City of Balto Highway Engineers Dept Md

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Henry Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Daisy V. Johnson

(Address) 217 S. Gilmor St

Filed 1927 C. HAMPSON JONES, M. D.

Per Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 1927

17 I HEREBY CERTIFY, That I attended deceased from 3-17 1927 to 3-19 1927, that I last saw h in alive on 3-19 1927, and that death occurred, on the date stated above, at 1.30 a m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia, post-operative.

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Cholecystitis and cholelithiasis (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3-2-27

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) [illegible] M. D.

3 19 1927 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery DATE OF BURIAL 3/22/27

20 UNDERTAKER Harry A. Wilkes ADDRESS 1531 N. Londonst

Spec.—1-12-23—M&T—500 Bks.

É 20408

# HEALTH DEPARTMENT—CITY OF BALTIMORE

É 20408

## CERTIFICATE OF DEATH.

REGISTERED NO. 15-58 23

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2923 Reistertown Rd St., WARD)

2-FULL NAME Henrietta Maria Magill

(a) RESIDENCE NO. 2923 Reistertown Rd St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Arthur Eugene Magill

6 DATE OF BIRTH (month, day, and year) 7/6/84

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 42 | 8 | 15 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mt Vernon. Md

PARENTS

10 NAME OF FATHER Henry J. E. Bounds

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Henrietta E. Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Arthur E Magill

(Address) 2923 Reistertown Road

15 Filed MAR 1927, 19 Registrar C. HAMPSON JONES, M. D.

By RKA

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 21, 19 27

17 I HEREBY CERTIFY, That I attended deceased from March 10, 19 27, to March 21, 19 27.

that I last saw her alive on March 21, 19 27

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Encephalitis Lethargica.

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical & conclusions

(Signed) Reinhard Barb M. D.

, 19 (Address) 2104 Eutaw Place Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Vernon, Md

DATE OF BURIAL Mar 22 19 27

20 UNDERTAKER Wm J Jenkins & Sons

ADDRESS Balto

Spec.—1-12-23—M&T—500 Blks.

**E 20410** HEALTH DEPARTMENT—CITY OF BALTIMORE **E 20409**

CERTIFICATE OF DEATH. 90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 919 St Paul ST. 11-15 WARD)

2-FULL NAME Annie E. Jackson

(a) RESIDENCE NO. 919 St Paul ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If ~~married~~, widowed, or ~~divorced~~, ~~HUSBAND of~~, (or) WIFE of Late Edward A. Jackson

6 DATE OF BIRTH (month, day, and year) Dec 9th 1862

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min |
|---|---|---|---|---|
| | 63. | 3 | 11 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pittsburg Pa

PARENTS

10 NAME OF FATHER James B. Wurry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pittsburg Pa

12 MAIDEN NAME OF MOTHER Annie Shorb

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pittsburg Pa

14 Informant Mrs. Lucille (Address) 919 St Paul St

Filed 1 1927 C. HAMPSON JONES, M. D. Registrar

Per ADW

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21st 1927

17 I HEREBY CERTIFY, That I attended deceased from 9-11, 19 26, to Mar 20, 1927, that I last saw her alive on March 20, 1927 and that death occurred, on the date stated above, at 3-21-27 3 45 4 m

The CAUSE OF DEATH* was as follows:

Huntington's Chorea

Myocarditis

(duration) 1 yrs mos ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs mos 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) [illegible] M. D.

, 19 (Address) 140 St Paul Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pittsburg Pa DATE OF BURIAL March 22 1927

20 UNDERTAKER Henry H Jenkins & Co ADDRESS Cathedral & Madison Sts

Spec.—1-10-21—M&T—1500 Bks.

E 20410

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20410

## CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2722 Fenwick Ave. ST. 4-46 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace Kirsch.

(a) RESIDENCE No. 2722 Fenwick Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married. |

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Charles A. Kirsch.

6 DATE OF BIRTH (month, day, and year) July 12, 1882

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 44 | 8 | 7 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore. (State or country) Maryland.

PARENTS

10 NAME OF FATHER William Curtain.

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Molly Ryan.

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland.

14 Informant Mrs. Grace Hellen. (Address) 1422 N. Broadway

15 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 1927

17 I HEREBY CERTIFY, That I attended deceased from March 11. 1927. to March 19. 1927.

that I last saw her alive on March 19. 1927.

and that death occurred, on the date stated above, at 7.20 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings —

(Signed) Chas. Welbun Stewart, M. D.

3/19 1927 (Address) 1738 E. 28th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore DATE OF BURIAL Mar 22 1927

20 UNDERTAKER Rita Wiedefeld ADDRESS 917 Fremont Ave

Spec.—1-12-23—MAT—500 Blks.

E 2041 HEALTH DEPARTMENT—CITY OF BALTIMORE E 2041

CERTIFICATE OF DEATH. 146

1-PLACE OF DEATH St Josephs Hospital

CITY OF BALTIMORE: (No. Catalina ? alley ST., Eastern WARD)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Victoria Josephine Kruszewska

(a) RESIDENCE NO. 825 S. Linwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. — mos. — ds. How long in U. S., if of foreign birth? 20 yrs. — mos. — ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | white | married |

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 1891

| 7 AGE 35 Years | Months 3 | Days — | If LESS than 1 day, hrs. or ... min. |
|---|---|---|---|

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Joseph —

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Zofia Kwoka

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address)

15 1927 C. HAMPSON JONES, M. D. Registrar

Per

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/19/27 1927

17 I HEREBY CERTIFY, That I attended deceased from 3/11/27, 1927, to 3/19/27, 1927, that I last saw her alive on 3/19/27, 1927, and that death occurred, on the date stated above, at 5.50 p m.

The CAUSE OF DEATH* was as follows:

peripheral sepsis

(duration) yrs. — mos 8 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

septicemia (duration) yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of 3/11/27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. A. M. S. Cornell M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Holy Cross Cem | Mar 22 1927 |
| 20 UNDERTAKER | ADDRESS |
| Wm. H. Gallagher | Linwood |

E 20412 HEALTH DEPARTMENT—CITY OF BALTIMORE E 20412

CERTIFICATE OF DEATH. 90

1-PLACE OF DEATH

City of BALTIMORE: (No. 4154 Falls Road 13-57 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. George W. Zimmerman

(Residence in Baltimore: No. 4154 Falls Road St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX. Male

4-COLOR OR RACE. White

5- ~~Married~~, ~~Widowed~~, ~~Divorced~~, (Write the word.) Married

6-DATE OF BIRTH, Nov 27 (Month) 1858 (Day) (Year)

7-AGE. 68 yrs. 3 mos. 21 ds. If LESS than 1 day, ....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Engineer
(b) General nature of industry, business, or establishment in which employed (or employer). Retired

9-BIRTHPLACE, (State or Country). Balto City

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER. (State or Country) Unknown

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER. (State or Country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Blanche Zimmerman

(Address) 4154 Falls Road

15- Filed 2 1 1927 C. HAMPSON JONES, M. D. Per ..... 192.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 20 (Month) (Day) 192 7 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary Disease of Heart

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.
3/24 192 (Coroner) (Address) 5572 Roland Ave

*Give the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Woodlawn DATE OF BURIAL March 23 1927

20-UNDERTAKER. Cohenouth & Son ADDRESS 3611 Eastern Ave

Spec.—7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20413 3
20413

100-101

E 20413

## CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Bucks Lane Arlington Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence E Witt

(a) RESIDENCE NO. Bucks Lane Arlington Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 26, 1926.

7 AGE: Years 1 Months 1 Days 22 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ooo

(b) General natore of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) md.

(State or country)

PARENTS

10 NAME OF FATHER Clarence H. Witt

11 BIRTHPLACE OF FATHER (City or town) Va

(State or country)

12 MAIDEN NAME OF MOTHER Catherine A. Parks

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Clarence H. Witt

(Address) Bucks Lane Arlington

15 Filed ..., 19.. C. HAMPSON JONES, M. D.

MAR 21 1927 Per ... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 19 27

17 I HEREBY CERTIFY, That I attended deceased from 3-13- 1927 to 3-19- 1927

that I last saw ~~him~~ alive on March 19- 1927

and that death occurred, on the data stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows: Bronchial Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? at home

Did an operation precede death? No Data of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. F. Hardesty, M. D.

19 (Address) 916 E. 20th.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injory, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse sida for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet — Date of Burial March 23 1927

20 UNDERTAKER Ehrenwerth Son & Chestnut — ADDRESS 341

Very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E.20414

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 20414

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (N 608 S Fulton ave 14-28 Ward)

2-FULL NAME Angie R. Bryan (Bryan)

(a) RESIDENCE NO. 608 S. Fulton St. Ward

(Usual residence)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Stephen E. Bryan

6 DATE OF BIRTH (month, day, and year): [illegible] 1878

7 AGE: Years 49 | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): [illegible]

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md

PARENTS

10 NAME OF FATHER: [illegible] Wilson

11 BIRTHPLACE OF FATHER (city or town): Baltimore

(State or country): Md

12 MAIDEN NAME OF MOTHER: Anne Gorsuch

13 BIRTHPLACE OF MOTHER (city or town): [illegible]

(State or country): Md

14 Informant: Carrie F. Chaney

(Address): 1714 Cole st

15 Filed: 1927

C. HAMPSON JONES, M. D.

Registrar

Per [illegible]

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/19/27 19

17 I HEREBY CERTIFY, That I attended deceased from 3/1/27 19 , to 3/19/27 19 ,

that I last saw her alive on 3/18/27 , 19 ,

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Hypertension + Mitral & Aortic Regurgitation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted —

If not at place of death]

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? None

(Signed) C. Bernard J. Feeney, M. D.

3/21/27 (Address) 910 W. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem. Date of Burial: 3-22-1927

20 UNDERTAKER: Robert Burns & Son ADDRESS: Calhoun Hollins

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20415 E 20415

## CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. ~~22~~ 1313 N. North Ave. St. 15-68 Ward)

2-FULL NAME Andrew N. Pledge.

(a) RESIDENCE NO. 2413 N. North Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Stella Pledge.

6 DATE OF BIRTH (month, day, and year): 11/17/70

7 AGE: Years 56 | Months 4 | Days 2 | If LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Foreman.

(b) General nature of industry, business, or establishment in which employed (or employer): Oil

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Richmond Va.

PARENTS

10 NAME OF FATHER Joseph N. Pledge.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va.

12 MAIDEN NAME OF MOTHER Amy D. Whiteford

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant W. Pledge

(Address) 2413 N. Northern Ave

15 Filed 1 1927 Per

C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 19 19 27

17 I HEREBY CERTIFY, That I attended deceased from Sept, 1926, to March 19, 1927, that I last saw him alive on March 14, 1927, and that death occurred, on the date stated above, at 2:15 P m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis
Chronic Nephritis
Arteriosclerosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Chas F Wesselhoeft, M. D.

, 19 (Address) 1000 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. Date of Burial: 3/22 1927

20 UNDERTAKER: J. J. Gahagan & Sons ADDRESS: 138 Eighth

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E·20416

E·20416

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1131 Hanover St. 23-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Hailey

(a) RESIDENCE NO. 1131 Hanover St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | white | widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Patrick Hailey

6 DATE OF BIRTH (month, day, and year) June 2. 1852

| 7 AGE | Years | Months | Days | IF LESS than 1 day ...hrs. or ...min.. |
|---|---|---|---|---|
| | 74 | 9 | 16 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ireland
(State or country)

PARENTS

10 NAME OF FATHER Peter Casey

11 BIRTHPLACE OF FATHER (City or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Mary Moran

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Gilbert J. Bailey
(Address) 1219 S. Charles St.

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18 19 27

17 I HEREBY CERTIFY, That I attended deceased from Mar. 1 1927 to Mar. 18 1927

that I last saw h... alive on 3/18 1927

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

(duration) ... yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary) Asthma Eczema

(duration) 1 yrs. ... mos. ... ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Hamilton Jones, M. D.

, 19 (Address) 1324 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem. Date of Burial March 22 1927

20 UNDERTAKER Margaret A. Flynn ADDRESS 1422 Light St.

A. HAMILTON JONES, M. D.

Very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 E 20417

E 20417

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of BALTIMORE: (No. 301 N. Carey St. 18-76 Ward)

2-FULL NAME Mae E. Zervis

(a) RESIDENCE NO. 301 N. Carey St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 13th 1889

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 37 | 10 | 4 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town)

(State or country) Pa

PARENTS

10 NAME OF FATHER John H. Zervis

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Pa

12 MAIDEN NAME OF MOTHER Clara A. Kirkham

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Pa

14 Informant Clara A. Zervis

(Address) 301 N. Carey St

Filed MAR 22 1927 E. HAMILTON JONES, M. D., Registrar

Per

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19th 1927

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by Inquest, Autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis Unknown (duration yrs. mos. ds.)

CONTRIBUTORY (Secondary) Heart failure (duration yrs. mos. ds.)

(Signed) Thos. B. Norton M. D. (Coroner)

Mch 21st 1927 (Address) Curtis Bay, Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See Reverse for additional data.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Moulton Park Cemetery Date of Burial 3/22 1927

20 UNDERTAKER George J. Smith ADDRESS 1822 Hoden St

Key important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

# E 20418 HEALTH DEPARTMENT—CITY OF BALTIMORE E 20418

## CERTIFICATE OF DEATH.

43

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3425 Chestnut Ave ST. 13-52 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John D. Hunt

(a) RESIDENCE No. 3425 Chestnut Av ST., ..... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Feb 1862

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or ..... min. |
|---|---|---|---|---|
| | 65 | Feb | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Gov't

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City Md

PARENTS

10 NAME OF FATHER William Hunt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Virginia Dickey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Leland

14 Informant Mrs. Smith

(Address) 3429 Chestnut Ave

15 Filed APR 22 1927 19.. Per ..... Registrar

J. HAMPTON JONES, M. D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 24 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept. 1926 to March 21 1927, that I last saw him alive on March 20 1927, and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Colon

Jaleta

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) W. H. Smith, M. D.

, 19 (Address) 3429 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lakemount Cemetery DATE OF BURIAL May 13 27

20 UNDERTAKER J. Allan Marshall ADDRESS 3539 Fait Ave

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- may be properly classified.

Spec.—12-9-25—A Co.—200 Bks.

Kell.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74001

E 20419

# CERTIFICATE OF DEATH.

E 20419

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1511 E Fayette St. 19-27 Ward)

2-FULL NAME Caroline Kell

(a) RESIDENCE NO. 1511 E Fayette St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | colored | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 62 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None D.

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) md

PARENTS

10 NAME OF FATHER Sam Conyer

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Ellen Goldsberry

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Clara Dunn

(Address) 1511 E Fayette St

15 Filed MAR 22 1927 HAMPSON JONES, M. D. Registrar

Per

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 19 1927

17

I HEREBY CERTIFY, That I attended deceased from Mar 15, 1927, to Mar 19, 1927, that I last saw h.. alive on Mar 19, 1927, and that death occurred, on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

Infirmity (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Edward Fahr, M. D.

3-21, 1927 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Adbury Cemetery March 22 27

20 UNDERTAKER ADDRESS

J. H. Rochester 1913 Jefferson St

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20420

## CERTIFICATE OF DEATH.

E 20420
REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. St. Joseph's Hospital ST., 9-47 WARD)

2-FULL NAME Mrs. Gladys C. Cunning

(a) RESIDENCE No. 725 Mc Henry Ave WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. 10 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | W hite | married |

5a If married, widowed, or divorced
~~HUSBAND of~~ or) WIFE of Thomas P. Cunning

6 DATE OF BIRTH (month, day, and year) May 19, 1902

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 24 | 10 | 2 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS
10 NAME OF FATHER John Leth
11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md
12 MAIDEN NAME OF MOTHER Deutcroma Abrams
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14
Informant John Leth
(Address) 725 Mc Henry Ave

15
Filed MAR 22 1927 19 C. FRANCIS JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/21 1927

17
I HEREBY CERTIFY, That I attended deceased from 3/20, 1927, to 3/21, 1927.
that I last saw h~~er~~ alive on 3/21, 1927,
and that death occurred, on the date stated above, at 4 05 A m.
The CAUSE OF DEATH* was as follows:

Inversion of Uterus
with Post Partum Bleeding

(duration) yrs. mos 1 ds.
CONTRIBUTORY (Secondary) Cardiac Debilitation
(duration) yrs. mos. 2 hrs

18 Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of 3/21/27
Was there an autopsy? No
What test confirmed diagnosis? Operation & Clinical
(Signed) H R ~~Mc~~ Mc ~~Kenna~~ M. D.
(Address) 5 E Pleasant Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Park Cem.
DATE OF BURIAL Mar 23 1927
20 UNDERTAKER Harry W. Ehlen
ADDRESS 1926 W. Nood Ave

Spec.—8-24-14—M. & T.—2000 Bks.

20421

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1001

7 E 20421

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 614 Pitcher St.; 14-20 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John W Jenkins

(Residence in Baltimore: No. 614 Pitcher St. St.; 16 yrs.. mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

| 3-SEX. | 4-COLOR OR RACE, | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) |
|---|---|---|
| male | Colored | widower |

6-DATE OF BIRTH, Dec. 25, 1867
(Month) (Day) (Year)

7-AGE, 59 60 yrs. 2 mos. 25 ds. If LESS than 1 day, ....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Huckster
(b) General nature of industry, business, or establishment in which employed (or employer)..... 045

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, George Jenkins

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William H. Jenkins

(Address) 614 Pitcher St.

15-

Filed....., 192.... C. HAMPSON JONES, M. D.

R 2 2 1927 Per ..... Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 20, 1927
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 1 1927, to March 20 1927, that I saw h[illegible] alive on March 19 1927, and that death occurred, on the date stated above, at 7A. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) John E. Daughaday M. D.

Mar 21 1927 (Address) 602 Runnells Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Carrolls Calvert Co. DATE OF BURIAL 3/22/27, 192..

20-UNDERTAKER Samuel Hawley ADDRESS 5 Bridge St.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20422

## CERTIFICATE OF DEATH.

51

E 20422

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) 3521 Gough St. 26-37 Ward

2-FULL NAME Sarah Wilson

(a) RESIDENCE NO. 3521 Gough St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~. (write the word): Widowed

5a If married, widowed, or divorced ~~HUSBAND~~ (or) WIFE of The late David Wilson

6 DATE OF BIRTH (month, day, and year) Jan 28-1864

7 AGE: Years 63 Months 1 Days 20 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md.

PARENTS

10 NAME OF FATHER William H. Hartlove

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER Bennetta Rulz

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Baltimore Md

14 Informant: Lauer Flats.

(Address) 718 Hollen Road

15 Filed [illegible] 1927

C. HAMILTON JONES, M. D.

Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) March 26 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Edocarditis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) M. D.

(Coroner)

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cemetery Date of Burial: Mar 29 1927

20 UNDERTAKER: Thos C. Hillestad ADDRESS 233 Dolfield

Key important. See instructions on back of certificate.

E 20423

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 20423

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 522 S Bouldin St. No. 2 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Paul F. H. Janne

(Residence in Baltimore: No. 522 S Bouldin St.; 35 yrs., mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

| 3-SEX | 4-COLOR OR RACE, | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) |
|---|---|---|
| Male | White | Married |

6-DATE OF BIRTH, Nov. 19, 1868 (Month) (Day) (Year)

7-AGE, 58 yrs. 4 mos. 1 ds. If LESS than 1 day, ....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): 015

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Earl Janne

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Charlotta Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Emma Janne

(Address) 522 S Bouldin St.

15- Filed ..... 1927 ..... 191... HAMPSON HAYES, M. D. Registrar.

Per .....

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 21, 1927 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis (Chronic)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Edema of Lungs

(Duration) yrs. mos. ds.

(Signed) M. D.
(Coroner.)

....., 191... (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

| 19-PLACE OF BURIAL OR REMOVAL, | DATE OF BURIAL, |
|---|---|
| Int. German Cem. | Mar. 23, 1927 |

| 20-UNDERTAKER | ADDRESS |
|---|---|
| Peter Nicolaus & Sons | 2923 Eastern Ave |

Important. See instructions on back of certificate.

MAR 22 1927

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20424

## CERTIFICATE OF DEATH.

60-00

E 20424

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2504 Maryland St., Ave. WARD) 12-51

2-FULL NAME Florence Watts

(a) RESIDENCE No. 2504 Maryland ST., Ave. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | white | single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 18, 1867

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 59 | 8 | 3 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home duties

(b) General nature of industry, business, or establishment in which employed (or employer) NO

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore County, Md.

PARENTS

10 NAME OF FATHER Nathaniel Watts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Co. Md.

12 MAIDEN NAME OF MOTHER Imogene Loyston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Co. Md.

14 Informant J. Clinton Watts
(Address) 2507 Maryland Ave

APR 22 1927 19 HAMPSON GAINES, M. D.
Filed Registrar
Per

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 21 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1926 to Mar 21, 1927.

that I last saw h[illegible]ive on Mar 20, 1927.

and that death occurred, on the date stated above, at 12 30 a m.

The CAUSE OF DEATH* was as follows:

(Thyroid - Goiter)

(duration) 2 yrs 3 mos ds.

CONTRIBUTORY (Secondary) (Cardiac Failure)

(duration) yrs 3 mos ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Typical

(Signed) J. Miller Thomas, M. D.

19 (Address) 1228 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Stone Chapel Cem'y. Balto. Co.

DATE OF BURIAL March 25, 1927

20 UNDERTAKER John A. Mitchell

ADDRESS 1900 Eutaw Pl.

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20425

## CERTIFICATE OF DEATH.

74-001

E 20425
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1504 Bolton ST. 14-20 (WARD)

2-FULL NAME Minna Lurman

(a) RESIDENCE No. 1504 Bolton ST. WARD
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~ (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) ~~WIFE of~~

6 DATE OF BIRTH (month, day, and year) Dec 12 1854

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min |
|---|---|---|---|---|
| | 72 | 3 | 8 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None
(c) Name of employer: None

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Gustav Lurman

11 BIRTHPLACE OF FATHER (city or town) Bremen
(State or country) Germany

12 MAIDEN NAME OF MOTHER Frances L Donnell

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant Redmond C. Stewart
(Address) Eccleston P.O. Md

15 Filed MAR 22 1927 HAMPSON JONES, M. D.
Registrar
Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 1927

17 I HEREBY CERTIFY, That I attended deceased from ~~Dec~~ 1926, to 3-20 1927,
that I last saw h~~e~~r alive on 3-20 1927,
and that death occurred, on the date stated above, at 7:15 m.
The CAUSE OF DEATH* was as follows:
CEREBRAL HEMORRHAGE

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) ARTERIO SCLEROSIS
(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) [illegible], M. D.
1927 (Address) 129 W. Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Greenmount Cem | March 22 1927 |
| 20 UNDERTAKER | ADDRESS |
| Henry H. Jenkins & Sons Co | Oakland & Mc Culloh Sts |

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20426

## CERTIFICATE OF DEATH.

8 | E 20426

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1144 Scott ST. 21-24 WARD)

2-FULL NAME Matilda Clara Kittle

(a) RESIDENCE NO. 1144 Scott ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | W. | — |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 16. 1921

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 5 | 10 | 4 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Arthur A. Kittle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Attica N. Y.

12 MAIDEN NAME OF MOTHER Amanda Tracey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Arthur A. Kittle
(Address) 1144 Scott St.

15 Filed MAR 22 1927 C. HAMPSON JONES, M. D. Registrar Per R.J.C.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 20 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb 1, 1927, to Mar 20, 1927, that I last saw h[illegible] alive on Mar 20, 1927, and that death occurred, on the date stated above, at 12.15 P. m.

The CAUSE OF DEATH* was as follows:

Chorea

(duration) 1 yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) T. E. H. Campbell M. D.

Mar 21, 1927 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Woodlawn | Mar 23, 1927. |
| 20 UNDERTAKER | ADDRESS |
| Mr & Mrs John W. Tempel & Son | 801 W Fayette St |

SEE INSTRUCTIONS ON BACK OF CERTIFICATES.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 20427
1-PLACE OF DEATH

92 E 20427
REGISTERED NO.

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Olive Virginia Bigham

(a) RESIDENCE NO. 1501 Bolton Street St. Ward Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. 6 mos. 1 ds. How long in U. S., if of foreign birth? 73 yrs. 6 mos. 1 ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Sept-19-1853

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 73 | 6 | 1 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER John Bigham

11 BIRTHPLACE OF FATHER (city or town) ? ?

(State or country) Scotland

12 MAIDEN NAME OF MOTHER Maria Forster

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant Miss S. Janet Ball (friend)

(Address) 1501 Bolton Street

15 Filed [illegible] 1927 C. HAMPSON JONES, M. D.
Registrar

MAR 22 1927 Per RLC

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

March 20, 1927

17 I HEREBY CERTIFY, That I attended deceased from March 19, 1927, to March 20, 1927, that I last saw her alive on March 20, 1927, and that death occurred, on the date stated above, at 7:45P m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R. Lindsay Smith, M. D.

3/20 1927 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — Date of Burial March-22-27

20 UNDERTAKER STEWART & MOWEN COMPANY — ADDRESS 1031 N. NORTH AVE.

Very Important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 20428

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

101-001

E 20428

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1123 E. Fayette St., 4-16 WARD)

2-FULL NAME Meyer Paymer

(a) RESIDENCE No. 1123 E. Fayette St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | white | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Paymer

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 69 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 2nd hand Clothing

(b) General nature of industry, business, or establishment in which employed (or employer) Dealer 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Barney Paymer

(Address) 100 N. Gilmor St

15 Filed MAR 2 1927 19 C. HARRISON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/22 1927

17

I HEREBY CERTIFY, That I attended deceased from March 19, 1927, to March 22, 1927, that I last saw h[illegible] alive on March 20th 1927 and that death occurred, on the date stated above, at 2a m

The CAUSE OF DEATH* was as follows:

Pneumonia lobar

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Oedema of lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Exam ext

(Signed) Joseph Friedman, M. D.

3/22, 1927 (Address) 32 at Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Hebrew Hebrew Rest | 3/22 1927 |
| 20 UNDERTAKER | ADDRESS |
| D Jack Levin | 1409 Eutaw St |

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 29429 Rehren

## CERTIFICATE OF DEATH.

12 E 20429

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Hebrew Home

CITY OF BALTIMORE: (No. 2100 E Balto St. 6-10 WARD)

2-FULL NAME Abraham Singer

(a) RESIDENCE No. 2100 E Balto St. ST. ..... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? 36 yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rebecca Singer

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 78 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... married

(b) General nature of industry, business, or establishment in which employed (or employer) aged

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Louis Singer (Address) 1220 E Biddle St

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

12 1927 per .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/22 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1923, to March 21, 1927, that I last saw h alive on March 3, 1927 and that death occurred, on the date stated above, at 4 a m

The CAUSE OF DEATH* was as follows:

Chronic Nephritis.

(duration) 6 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Samuel Levinthal, M. D.

, 19 (Address) 1810 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Hebrew Int Comel | 3-22-27 19 |
| 20 UNDERTAKER Jack Lewis 1489 Bank | ADDRESS |

Spec.—12-9-25—A Co.—200 Bks.

E 20430

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 20430

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO. 6229

City of BALTIMORE: (No. [redacted] Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Marsh

(a) RESIDENCE NO. 1018 Appleton St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1871

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 56 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bakers Helper

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER George Marsh

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Mary —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant BALTIMORE CITY HOSPITALS

(Address) [redacted] Brooks

15 Filed MAR 22 1927 19 Per [signature] Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 1927

17

I HEREBY CERTIFY, That I attended deceased from March 17, 1927, to March 20, 1927, that I last saw him alive on March 20, 1927, and that death occurred, on the date stated above, at 8 45 A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia
Chronic Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY Myocardial failure
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? gen'l & Laboratory

(Signed) R. Hoopes Linell, M. D.

Md. 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Mt Olivet 6 cm March 22 1927

20 UNDERTAKER — ADDRESS

C. Howard Evans 38 E. Fayette Ave

Very Important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20431

## CERTIFICATE OF DEATH.

74-001

E 20431

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 558 W. Mosher St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary M. Mathews

(a) RESIDENCE NO. 558 W. Mosher St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 11 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | colored | married |

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. Mathews

6 DATE OF BIRTH (month, day, and year) March 23, 1884

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 43 | 11 | 29 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) (37)

(c) Name of employer General

9 BIRTHPLACE (city or town) Mt. Hope

(State or country) Md.

PARENTS

10 NAME OF FATHER Wm. H. Bowley

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Emma Howard

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Wm. Mathews

(Address) 558 W. Mosher St.

15 Filed March 29, 1927 19 C. HAMPTON JONES, M. D. Registrar

Per W.H.

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 192 7

I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Alcoholism

(duration) yrs. mos. ds.

(Signed) C. H. Jones (Coroner) M. D.

(Address) 1 W Mt Royal Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death..... yrs..... mos.,..... ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Cemetery Date of Burial Mar. 22, 1927

20 UNDERTAKER Mrs. Katie R. Williams ADDRESS 322 N. Schroeder St

Very important. See instructions on back of certificate. CAUSE OF DEATH. OCCUPATION IS

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

20432

## CERTIFICATE OF DEATH

X-20-E 20432

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital W-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harold Greaves.

(a) RESIDENCE NO. Lutherville Md St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Known.

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day ... hrs. or ... min. |
|---|---|---|---|---|
| | 25 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hooker Hookster

(b) General natore of indostry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland

(State or country)

PARENTS

10 NAME OF FATHER Edgar Greaves.

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Poole

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant

(Address) John Burns Sons Town

15 Filed 19 C. HAMPSON JONES, M. D.

Par Registrar

4-2-1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 21 1927.

17 I HEREBY CERTIFY, That I attended deceased from Mar 15, 1927 to Mar 21, 1927.

that I last saw him alive on Mar 21, 1927.

and that death occurred, on the date stated above, at 7 30 P m.

The CAUSE OF DEATH* was as follows:

Brain Abscess

(duration) yrs. mos. 10 da.

CONTRIBUTORY (Secondary) Antrum Infection

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) E Kemler, M. D.

. 19 (Address) University Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mayo's Cem. Balto Co.

Date of Burial March 23 1927

20 UNDERTAKER John Burns Sons

ADDRESS Town

very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20433

## CERTIFICATE OF DEATH.

3 E 20433

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 616 N. Carey St. (ST.) 16-23 (WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan Bowie Sanders -

(a) RESIDENCE NO. 616 N. Carey St ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 27 1857

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs or ....min. |
|---|---|---|---|---|
| | 69 | 9 | 17 21 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER George W Sanders

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Susan Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Margaret Sanders (Address) 616 N Carey St

15 Filed MAR 22 1927 Registered by C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18 1927

17 I HEREBY CERTIFY, That I attended deceased from January 28, 1927, to March 18, 1927, that I last saw h[illegible] alive on March 18, 1927, and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) — yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Findings

(Signed) Helen F. Sherman, M. D.

, 19 (Address) 6 East Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem DATE OF BURIAL 3/22 1927.

UNDERTAKER George J Smith ADDRESS Hollins & Gilmor Sts

THIS is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 20434

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129 E 20434

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 414 Mott St. 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Solomon Matthews

(a) RESIDENCE NO. 414 Mott ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Col | Widower |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emeritta Matthews

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs. or ....min. |
|---|---|---|---|---|
| | 70 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Oyster Shucker 24

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Thos Matthews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Gertie Matthews

(Address) 414 Mott St.

15 Filed MAR 22 1927 HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-21 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan 12 1927 to March 21 1927

that I last saw h alive on March 21 1927

and that death occurred, on the date stated above, at 4 A.M. m.

The CAUSE OF DEATH* was as follows:

Chronic Brights Dis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Albumen Urine Renal Casts

(Signed) W Clyde Bunting M. D.

3-22-27 (Address) 2613 E 32nd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Forest Lawn

DATE OF BURIAL 3-24 1927

20 UNDERTAKER Chas. G. Bailey

ADDRESS 1618 Jefferson St

Spec.—12-9-25—A Co.—200 Bks.

# E 20435 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

49 E 20435

REGISTERED NO.

1-PLACE OF DEATH Sinai Hospital

City of BALTIMORE: (No. 7-12 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anton Rojik

(a) RESIDENCE NO. 909 - N. Duncan St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (~~or WIFE of~~): Mrs A. Rojik

6 DATE OF BIRTH (month, day, and year): August 27 1873

7 AGE: Years 53 Months 6 Days 24 IF LESS than 1 day.....hrs. or.....min. (1873 / 22)

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailor

(b) General nature of industry, business, or establishment in which employed (or employer): Not Know

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Bohemia

PARENTS

10 NAME OF FATHER: Anton Rojik

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Bohemia

12 MAIDEN NAME OF MOTHER: not know

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): not know

14 Informant: Albina Rojik

(Address): 909 north Duncan st

15 Filed ... 1927 ... 19 ... HAMILTON JONES, M. D. ... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3 - 21 1927

17

I HEREBY CERTIFY, That I attended deceased from 3 - 19 1927, to 3 - 21, 1927,

that I last saw him alive on 3 - 21, 1927,

and that death occurred, on the date stated above, at 1.30 A m.

The CAUSE OF DEATH* was as follows:

Malignancy of Pancreas (gross) to be proven by microscopic section

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary): Myocardial failure

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Barbara Liede, M. D.

, 19 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Hill — Date of Burial 3/23 1927

20 UNDERTAKER: August Pasek — ADDRESS 2406 Eastland ave.

Very important. See instructions on back of certificates. Statement of OCCUPATION is

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20436

## CERTIFICATE OF DEATH

101-001 E 20436

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1103 N. Mountford Ave St., (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. M. Pirie

(a) RESIDENCE NO. 1103 N. Mountford Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 Color or Race: W

5 Single, Married, Widowed, or Divorced. (write the word): married

5a If ~~married, widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~: Katherine Pirie

6 DATE OF BIRTH (month, day, and year): Nov 19 1883

7 AGE: Years 43 Months 4 Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer): 066

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Wm M. Pirie

11 BIRTHPLACE OF FATHER (City or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary J Cowley

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Maryland

14 Informant: Mary J Pirie

(Address) 2423 E Federal St

15 Filed MAR 22 1927 19 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 19 19 1927

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1927, to March 19, 1927, that I last saw him alive on March 19, 1927, and that death occurred, on the date stated above, at 7.8 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary): Acute Pleurisy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. H. Herzog M.D. M. D.

Mar 20 1927 (Address) 1305 N Milton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — Date of Burial: Mar 23 1927

20 UNDERTAKER: Robt J Turner Sr — ADDRESS: 1642 N Broadway

very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

# E 20437 HEALTH DEPARTMENT—CITY OF BALTIMORE E 20437

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St., 1-1 Ward)

Registered No. 167

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Ludlum

(a) Residence No. 801 S. Lakewood St., Ward.
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced (Write the word.) Infant

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) March 16 '27

7-AGE. yrs. mos. 1 ds. If LESS than 1 day hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. ds
(b) General nature of Industry, business, or establishment in which employed (or employer).
(c) Name of employer.

9-BIRTHPLACE (city or town). Baltimore, Md.
(State or Country). Maryland

PARENTS.

10-NAME OF FATHER Jacob Charles Ludlum

11-BIRTHPLACE OF FATHER (city or town). Baltimore
(State or Country). Maryland

12-MAIDEN NAME OF MOTHER Mary Theresa McKenney

13-BIRTHPLACE OF MOTHER (city or town). Baltimore
(State or Country). Maryland

11- (Informant) Mary Ludlum
(Address) 801 S. Lakewood

15- Filed MAR 22 1927 192 C. HAMPSON JONES, M. D. Registrar.
Per

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 17, 1927

17- I HEREBY CERTIFY, That I attended deceased from March 16 19 27 to March 17 19 27, that I last saw h[illegible]alive on March 17 19 27 and that death occurred, on the date stated above, at 10:30A M.

The CAUSE OF DEATH* was as follows:

Prematurity - Congenital atelectasis,

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Maternal nephritis,

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No, Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Margaret B. Ballou M. D.
19 (Address) University Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Leverly - of Md — DATE OF BURIAL 19

20-UNDERTAKER — ADDRESS

Spec.—1-10-21—M&T—1500 Blks.

Dr. Condon

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20438

## CERTIFICATE OF DEATH.

64 129

E 20438

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 200 Gaunin Lane St., (Ward) 19

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna H. Horst.

(a) RESIDENCE No. 200 Gaunin Lane St. WARD 19

(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. — mos. — ds. How long in U. S., if of foreign birth? 68 yrs. — mos. — ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Ernst Horst

6 DATE OF BIRTH (month, day, and year): Dec 26 1837

7 AGE: Years 89 Months 2 Days 27 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Ernst H. Horst

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Wally Seidelbach

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Anna H. Horst 200 E. Gaunin Lane

15 Filed MAR 22 1927 19 Registrar: HAMPTON JONES, M. D.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar. 19 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan 5, 1927, to Mar 19, 1927.

that I last saw h alive on Mar 18, 1927.

and that death occurred, on the date stated above, at 7:05 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac Mitral Stenosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Int. Nephritis

Arteriosclerosis (duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clinton A. Condon, M. D.

19 (Address) 733 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Mar 22 1927

UNDERTAKER: J. B. Wagner

ADDRESS: 850 N. Eutaw St.

IMPORTANT. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20439

## CERTIFICATE OF DEATH.

100-001

E 20439

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hospital St. 17-24 Ward)

2-FULL NAME Clifton Harris

(a) RESIDENCE NO. 1206 Shields alley St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | colored | single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 20, 1922

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 5 | 7 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Walter T. Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Julia Gibson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Walter T. Harris
(Address) 535 Lauder St

15 Filed....., 19.... C. HAMPSON JONES, M. D.
Per Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Jury at autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) no other history

(duration) yrs. mos. ds.

(Signed) J. T. Kennedy M. D.
(Coroner)

March 24, 19 27 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Mount Auburn Cem | March 23 1927 |
| 20 UNDERTAKER John H. Owens | ADDRESS 533 Dolphin St |

very important. See instructions on back of certificate. Exact statement of OCCUPATION is

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20440

## CERTIFICATE OF DEATH.

129 E 20440

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St., 13-59 Ward)

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Augustus La Bar

(a) RESIDENCE NO. 25-29 Madison Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | Negro | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Adell La Bar

6 DATE OF BIRTH (month, day, and year) 1882

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 45 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER August La Bar

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Esther Finley

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant BALTIMORE CITY HOSPITALS

(Address) [redacted]

15 Filed MAR 22 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 1927

17

I HEREBY CERTIFY, That I attended deceased from August 29, 1925, to March 20, 1927, that I last saw h[illegible] alive on March 19, 1927, and that death occurred, on the date stated above, at 2.30 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Hypertension (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Infarction

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? General & Laboratory

(Signed) R Hooper Lamb, M. D.

Mch 20 1927 (Address) BALTIMORE CITY HOSPITALS

[redacted]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

Date of Burial MAR 22, 1927

20 UNDERTAKER Samuel P Hemsley

ADDRESS 578 W Baltimore

very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20441

## CERTIFICATE OF DEATH

× 38

REGISTERED No. E 20441

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hosp St. W 30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Taylor

(a) RESIDENCE NO. Ellicott City Md St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 24 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| F | C | ~~Widow~~ (Married) |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of )

6 DATE OF BIRTH (month, day, and year) unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|---|
| | 45 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work N. W.

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Va

(State or country)

PARENTS

10 NAME OF FATHER Andrew Brown

11 BIRTHPLACE OF FATHER (City or town) Va

(State or country)

12 MAIDEN NAME OF MOTHER Blanche Gordon

13 BIRTHPLACE OF MOTHER (city or town) Va

(State or country)

14 Informant Hospital Records

(Address)

15 Filed MAR 27 1927 C. HAMPSON JONES, M. D. Registrar

Per R.M.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 27 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 21, 1927, to Mar 27, 1927, that I last saw her alive on Mar 27, 1927, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Syphilitic Stricture of Trachea.

Syphilitic Cardiovascular disease.

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Terminal Bronchopneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) E. R. Miller, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Gilboa Cem

Date of Burial: May 22 1927

20 UNDERTAKER: Easton Sons

ADDRESS: Ellicott City

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 20442

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20442

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Home for Incurables- 4 Codd's ave. ST., 14 WARD) REGISTERED NO. 14 170 24

2-FULL NAME Ruth Eleanor Maynard

(a) RESIDENCE No. 1608 Bolton St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single- |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 4 62

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 62 | 9 | 18 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Trained Nurse Ret'd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Co - Md

PARENTS

10 NAME OF FATHER Howard G - Maynard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah A. Chiswell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md -

14 Informant Miss Sarah E. Maynard (Address) 1608 Bolton St

15 Filed MAR 22 1927 Registrar

H. HARRISON JONES, M. D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21 1927

17 I HEREBY CERTIFY, That I attended deceased from Feby 18, 1927, to March 21 1927, that I last saw h[illegible] alive on March 21, 1927, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Hemiplegia) (duration) — yrs. 7 mos — ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation (duration) — yrs. — mos. 7 ds.

18 Where was disease contracted if not at place of death? Baltimore, Md.

Did an operation precede death? No Date of —

Was there an autopsy? No Hyperpiesia diagnosis

What test confirmed diagnosis?

(Signed) Wm J Mayo M. D.

3/21, 1927 (Address) Baltimore, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Frederick Md. DATE OF BURIAL 3/22 1927

UNDERTAKER W M Routson ADDRESS 2238 N North Ave

IMPORTANT—See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20443

CERTIFICATE OF DEATH. 11-001

E 20443

1-PLACE OF DEATH 1103 N Montford Ave 12 Registered No.

City of BALTIMORE: (No. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank J. Price

(a) Residence No. 1103 N Montford Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Viola Price

6-DATE OF BIRTH (month, day and year) Not Known

7-AGE. 42 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS.

10-NAME OF FATHER, William Price

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Scotland

12-MAIDEN NAME OF MOTHER, Mary J. Colby

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto

11- (Informant) Viola Price

(Address) 1103 N Montford Ave

15- FILED MAR 29 1927 Per Registrar.

C. HAMPSON JONES, M. D.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 3-20-27

17- I HEREBY CERTIFY, That I attended deceased from 3-19 1927 to 3-20 1927

that I last saw him alive on 3-20 1927

and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Myocardiac Insufficiency

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Influenzal Pneumonia

(Duration) yrs. mos. 6 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) Daniel Miller M. D.

3/20, 1927 (Address) 1500 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Balto Cem. DATE OF BURIAL, Mar 24 1927

20-UNDERTAKER, Pius Eversdon ADDRESS 1006 Hand

Spec.—1-12-23—M&T—500 Blks.

E 20444

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

88 E 20444

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1220 N. Luzerne ave ST., 8-12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Renner

(a) RESIDENCE No. 1220 N. Luzerne ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? 75 yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mollie Renner

6 DATE OF BIRTH (month, day, and year) Nov. 23-1849

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 77 | 3 | 28 27 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber 059

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer Gas + elec. co.

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Robt. C. Renner

(Address) 1220 N. Luzerne ave

15 Filed 3 22 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21 1927

17

I HEREBY CERTIFY, That I attended deceased from March 21, 1927, to March 21, 1927, that I last saw him alive on March 21, 1927, and that death occurred, on the date stated above, at 3.15 P. m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) B F Herzog MD M. D.

3/22, 1927 (Address) 1315 N Patterson Pk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Baltimore Cemetery | March 24, 27 |
| 20 UNDERTAKER Jinkler + Jinkler | ADDRESS 1739 E. Eager St. |

Spec.—12-9-25—A Co.—200 Blks.

1985 70 E 20445

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

× 49 E 20445

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Marshall

(a) RESIDENCE NO. Anchuca - S-C St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1910

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 17 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) S - Car -

(State or country)

PARENTS

10 NAME OF FATHER R. C. Marshall

11 BIRTHPLACE OF FATHER (city or town) S. C.

(State or country)

12 MAIDEN NAME OF MOTHER Emma Zapp

13 BIRTHPLACE OF MOTHER (city or town) S. C.

(State or country)

14 Informant Ricardo

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 2 2 1927 C. HAMPSON JONES, M. D. Registrar

Per

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan - 22 19 27

17

I HEREBY CERTIFY, That I attended deceased from Dec - 22, 1926, to Jan - 22, 1927, that I last saw h-er alive on Jan. 22, 1927, and that death occurred, on the date stated above, at 7 30 p. m.

The CAUSE OF DEATH* was as follows:

Sarcoma of bone with generalized metastases.

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

none (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) E. Cowles Andrus, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lanes S C Date of Burial 3/22/27

20 UNDERTAKER Joseph Ahrens ADDRESS 224 Bway

very important. See instructions on back of certificates. Full statement of OCCUPATION is

Spec.—12-9-25—A Co.—200 Bks.

E 20446

# HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 20446

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St., 323 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Hayward

(a) RESIDENCE NO. 118 W. Hamburg St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1840

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 87 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Hayward

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie —

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Maryland

BALTIMORE CITY HOSPITALS

Informant

(Address) Records

C. HAMPSON JONES, M. D.

2 1927 Filed_____, 19____

Per [illegible] Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 1927

17

I HEREBY CERTIFY, That I attended deceased from March 16, 1927, to March 20, 1927, that I last saw him alive on March 20, 1927, and that death occurred, on the date stated above, at 8.45 P m.

The CAUSE OF DEATH* was as follows:

Antemal Sclerosis

Chronic Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardeal failure

(duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes.

What test confirmed diagnosis? General & Laboratory

(Signed) R. Hoopes Smith, M. D.

March 22 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Ct Date of Burial 3/23/27

20 UNDERTAKER: Isaiah L Owens for Montgomery

very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 20447

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20447

## CERTIFICATE OF DEATH.

100-201

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 809 Fession ST. 17-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa Lucille Jones

(a) RESIDENCE NO. 809 Fession ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | colored | single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 16-1926

| 7 AGE Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|
| | 7 | 5 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Wm Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Rosetta Elliott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Rosetta Jones (Address) 809 Fession St.

15 Filed MAR 21 1927, 19 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 21 1927

17

I HEREBY CERTIFY, That I attended deceased from March 17, 1927, to Mar 21, 1927, that I last saw her alive on Mar 21, 1927, and that death occurred, on the date stated above, at 3 30 m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(Primary) (duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J K Carey, M. D.

, 19 (Address) 453 Dover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

DATE OF BURIAL March 22/27

20 UNDERTAKER Daniel Easton

ADDRESS Grave 9/6

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 20448 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

4# E 20448

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Baltimore Gen. Hosp. ST. 1900 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace Jones

(a) RESIDENCE NO. 839 W Lexington ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE

| Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|
| 67 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

10 NAME OF FATHER Plem Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Jane Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

PARENTS

14 Informant (Address) West Balt. Gen. Hosp. Records

15 Filed MAR 2 1927 C. HAMPSON JONES, M. D. Registrar

TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/20 1927

17

I HEREBY CERTIFY, That I attended deceased from 3/12, 1927, to 3/20, 1927, that I last saw her alive on 3/20, 1927, and that death occurred, on the date stated above, at 12 30 P.M.

The CAUSE OF DEATH* was as follows: Coronary thrombosis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 3/16/27

Was there an autopsy?

What test confirmed diagnosis? Clinical Autopsy

(Signed) Thomas R. Jones M. D.

Address West Baltimore Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem. DATE OF BURIAL: March 22/27

UNDERTAKER: Daniel Easton ADDRESS: 916 Gay St.

Spec.—12-9-25—A Co.—200 Bks.

E 20449

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 20449

REGISTERED NO._____

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Smith

(a) RESIDENCE NO. 112 Colvin St. _____ Ward _____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Negro | Widowed |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Widowed

6 DATE OF BIRTH (month, day, and year) 1862

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 65 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER James F. Williams

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary J. Johnson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant

(Address) Records

15 Filed _____ 19____ C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 1927

17

I HEREBY CERTIFY, That I attended deceased from January 31, 1927, to March 19, 1927, that I last saw h.. alive on March 19, 1927, and that death occurred, on the date stated above, at 330 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ? yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) ____ yrs. ____ mos. 4 ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? General & laboratory

(Signed) R. Hooper Smith, M. D.

Mch 28 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Auburn Ave Date of Burial March 22-1927

20 UNDERTAKER Daniel Easton ADDRESS Penn 916

very important. See instructions on back of certificates. Exact statement of OCCUPATIO... be properly classified.

Cor.—12-9-25—A Co.—200 Bks.

E 20450

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20450

## CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 631 N. Pulaski St. 16-27 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. G. Brown

(a) RESIDENCE NO. 631 N. Pulaski St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | widower |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) Aug. 11, 1863

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 63 | 7 | 9 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hotel Keeper

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer self.

9 BIRTHPLACE (city or town) N. Y.

(State or country)

PARENTS

10 NAME OF FATHER Wm. G. Brown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) N. Y.

12 MAIDEN NAME OF MOTHER Mary Grey

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) N. Y.

14 Informant Frank Stone

(Address) Atlantic City

15 Filed 19

C. HAMPSON JONES, M. D.

Per Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

(Signed) C. H. Jones M. D.

(Coroner)

(Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Date of Burial 19

20 UNDERTAKER Geo. W. Little ADDRESS

MAR 29 1927

Very important. See instructions on back of certificate. Exact statement of OCCUPA... is

4 2 1927

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 20451

E 20451

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 18-20 Ward)

2-FULL NAME George W. Walter

(a) RESIDENCE NO. 1007 Edmondson Ave, St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 28. 1861

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 65 | 11 | 23 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired (Carpenter)

(b) General nature of industry, business, or establishment in which employed (or employer) 15

(c) Name of employer

9 BIRTHPLACE (city or town) Hanford Co. Md

(State or country) Maryland

PARENTS

10 NAME OF FATHER Geo W Walter

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Cathrine Berger

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant John B Walter

(Address) 906 Windsor Ave

Filed 2 2 1927 C. HAMPSON JONES, M. D. Registrar

Per RRH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1927, to March 21, 1927, that I last saw him alive on March 21, 1927, and that death occurred, on the date stated above, at 8 55 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio sclerotic cardio-vascular disease

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Sheldon Eastland, M. D.

, 19 (Address) 7136 N. Calvert St.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Date of Burial MAR 24 1927 19

20 UNDERTAKER Geo W Little ADDRESS 2700 EDMONDSON AVE

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 20452

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20452

## CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Md General Hospital (St.) 9-46 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Augusta Marshall

(a) RESIDENCE NO. 54 E. 24th St. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs S. Marshall

6 DATE OF BIRTH (month, day, and year): Aug 4 1844

7 AGE

| Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|
| 82 | 7 | 17 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Abner Linthicum

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: May Bryan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Maryland

14 Informant (Address): Hospital Records.

15 Filed 3-22 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3-21-1927

17

I HEREBY CERTIFY, That I attended deceased from March 18, 1927, to March 21, 1927, that I last saw her alive on March 21, 1927, and that death occurred, on the date stated above, at 4.35 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary): Senility

(duration) 9 yrs. mos. ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Jno B Thompson M. D.

, 19 (Address) 1100 Eutaw St. opx

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore

DATE OF BURIAL: MAR 24 1927 19

20 UNDERTAKER: Geo W Little

ADDRESS 3708 Edmondson Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of C[illegible]

TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 20453

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

2/ E 20453

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Sinai Hospital St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Strasburger

(a) RESIDENCE NO. Walbrook Apts 1D St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Meyer H. Strasburger

6 DATE OF BIRTH (month, day, and year): Jany. 4, 1857

7 AGE: Years 70 Months 2 Days 18 IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Balto.

(State or country): Md.

PARENTS

10 NAME OF FATHER: Edward Goldsmith

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Caroline Hutzler

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Germany

14 Informant: Mr. Max Goldsmith (Address) Walbrook Apts 1D

15 Filed 2 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/22/27 19

17 I HEREBY CERTIFY, That I attended deceased from March 16 19 27, to March 22 19 27,

that I last saw h[illegible] alive on March 22 19 27,

and that death occurred, on the date stated above, at 2:00 A m.

The CAUSE OF DEATH* was as follows:

Emphysema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Embolic Pneumonia + Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) C. Hyman, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship Cem. Date of Burial 3/24/1927

20 UNDERTAKER: Aaron Sondheim ADDRESS 1820 W. Pratt & Royal Ave

Very important. See instructions on back of certificates.

E 20454 HEALTH DEPARTMENT—CITY OF BALTIMORE E 20454

CERTIFICATE OF DEATH. Registered No. C.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1617 E. Banks. St. B-4 Ward) 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Geo Lijewski

(Residence in Baltimore: No. 1617 E Banks. St.; Yrs. 41 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

| 3-SEX. | 4-COLOR OR RACE. | 5-Single, Married, Widowed, or Divorced. (Write the word.) |
|---|---|---|
| Male | White | Married |

6-DATE OF BIRTH. April 21 1860 (Month) (Day) (Year)

7-AGE. 66 yrs. 11 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.
(b) General nature of Industry, business, or establishment in which employed (or employer). Laborer

9-BIRTHPLACE. (State or Country). Poland

PARENTS.

10-NAME OF FATHER. Michael Lijewski

11-BIRTHPLACE OF FATHER. (State or Country). Poland

12-MAIDEN NAME OF MOTHER. Frances Matelski

13-BIRTHPLACE OF MOTHER. (State or Country). Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Lijewska

(Address) 1607 Bank St

15-

FILED MAR 22 1927 C. HAMPSON JONES, M. D. Registrar. Per AKH

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. March 21 1927 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) yrs. mos. 1 ds.

M. D.

(Coroner) (Address) 1437 E Biddle

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Holy Rosary DATE OF BURIAL. March 26 1927

20-UNDERTAKER. John M Weber ADDRESS 1203 Bank St

Is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

See letter on file from T. B Ayerch mtd April 2 '27 changing age from 65 to 54 yrs

HEALTH DEPARTMENT—CITY OF BALTIMORE

# CERTIFICATE OF DEATH.

E 20455

1-PLACE OF DEATH

E 20455

REGISTERED NO.

City of BALTIMORE: (No. Balto City Hospital 1-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ledwora Chelweski OR CZARNECKA

(a) RESIDENCE NO. 704 S Mumford Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? 26 yrs. mos. ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Andrew Chelweski

6 DATE OF BIRTH (month, day, and year): 1873

7 AGE: Years 54; Months; Days; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town): Poland

(State or country)

PARENTS

10 NAME OF FATHER: Joseph —

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Poland

12 MAIDEN NAME OF MOTHER: Elizabeth —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Poland

14 Informant: Hosp Record

(Address)

15 Filed 2 1927 C. HAMPSON JONES, M. D.

Per RRU Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 March 21, 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 22, 1927, to March 21, 1927, that I last saw h 26 alive on March 21, 1927, and that death occurred, on the date stated above, at 1 10 m.

The CAUSE OF DEATH* was as follows: Cellulitis & Right Hand and Arm

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Streptococcus Septicemia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of Feb 23, 1927

Was there an autopsy? yes

What test confirmed diagnosis? Clinical & Laboratory

(Signed) M. Blumwell M. D.

. 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Cem Date of Burial March 24 1927

20 UNDERTAKER: John W Weber ADDRESS 1803 Bank St

Be sure to have this certificate properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20456

## CERTIFICATE OF DEATH.

45 E 20456

1-PLACE OF DEATH

City of BALTIMORE: (No. Balt City Hospitals Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Pinkowski

(a) RESIDENCE NO. 279 S Ann St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1885

7 AGE: Years 42 | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cleaning Offices

(b) General nature of industry, business, or establishment in which employed (or employer): 1086

(c) Name of employer

9 BIRTHPLACE (city or town): Poland

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Hosp Record

(Address)

15 Filed 2 1927 C. HAMPSON JONES, M. D.

Per ROH Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 15, 27 to March 21, 1927, that I last saw her alive on March 21, 27, and that death occurred, on the date stated above, at 5.30 m.

The CAUSE OF DEATH was as follows:

Carcinoma of Rectum

duration ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

duration ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) [illegible] M. D.

, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rozary Date of Burial: March 24 1927

20 UNDERTAKER: John M Weber ADDRESS: 1803 Brook Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20457

## CERTIFICATE OF DEATH.

E 20457

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore General Hospital Ward) 24-33

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carl R.Lloyd.

(a) RESIDENCE NO. Girard, Pa. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male. | White. | Married. |

5a If married, widowed or divorced, HUSBAND of (WIFE of) Hazel G.Lloyd.

6 DATE OF BIRTH (month, day, and year) November 4, 1887.

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 39 | 4 | 17 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Telegraph operator.

(b) General nature of industry, business, or establishment in which employed (or employer) Co

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Girard, Pa.

PARENTS

10 NAME OF FATHER Frank A.Lloyd.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Girard, Pa.

12 MAIDEN NAME OF MOTHER Nellie Smith.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Girard., Pa.

14 Informant Hazel G.Lloyd.(wife)

(Address) Girard, Pa.

15 Filed C. HAMPSON JONES, M. D. Registrar

2 7 1927 Per

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Otto M Reinhardt M. D.

(Coroner)

3/22 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pittsburg Pa Amer Cem Co Date of Burial Mar 22 1927

20 UNDERTAKER John F. Denny ADDRESS 713 Light St

If DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 20458

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

90 E 20458

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 207 South Mount St. 19-25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David P. Spriggs

(a) RESIDENCE NO. 207 S. Mount St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): June 16 1860

7 AGE Years: 66 Months: 9 Days: 5

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 047

(b) General nature of industry, business, or establishment in which employed (or employer): Lim[illegible]

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Richmond Va

PARENTS

10 NAME OF FATHER: David P. Spriggs

11 BIRTHPLACE OF FATHER (City or town) (State or country): Richmond Va

12 MAIDEN NAME OF MOTHER: Catharine Canada Hill

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Richmond Va

14 Informant: Thomas D. Phillips

(Address) 2326 Edmondson Ave

Filed 1927 C. HAMPSON JONES, M. D., Registrar

Per ACH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: Mar. 20th 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 29, 1926, to Mar. 20, 1927, that I last saw h[illegible] alive on Mar. 20 1927 and that death occurred, on the date stated above, at 8.15 P m.

The CAUSE OF DEATH* was as follows:

Arterial Sclerosis

Myocarditis (Chronic)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis.

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Chronic Myocarditis

(Signed) Thos. H. Phillips, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park. Date of Burial: Mar 23 1927

20 UNDERTAKER: Wendell J. Leppel ADDRESS: 300 [illegible]

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Cor.—12-9-26—A Co.—200 Bks.

# E 20459

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

× 179 E 20459

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hosp St. 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hattie Shaw

(a) RESIDENCE NO. Carey Md St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 10 yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Shaw

6 DATE OF BIRTH (month, day and year) Nov. 24 1885

7 AGE: Years 41 Months 3 Days 27 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Harry Emory

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Amanda Emory

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Harry Shaw

(Address) Carey Md.

15 3/24 1927 C. HAMPSON JONES, M. D. Registrar

Per

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: 3rd degree burns of body. (accidental)

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) scalded by overturning of pot of hot water

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.

(Coroner)

3/24, 1927 (Address) 280 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Salisbury Md — Date of Burial 3/23 1927

20 UNDERTAKER: George J Ruth — ADDRESS 1735 Harlem

DEATH in plain terms, so that it may be very important. See instructions on back of

Exact statement of OCCUPATION is

may be properly classified.

check of certificate.

Spec.—12-9-25—A Co.—200 Blks.

E 20460

# HEALTH DEPARTMENT—CITY OF BALTIMORE

38 E 20460

## CERTIFICATE OF DEATH

1-PLACE OF DEATH Balto City Hospt

City of BALTIMORE: (No. Balto Md 4 30 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Caston

(a) RESIDENCE NO. 64 Cedar Alley Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE: Years 24; Months; Days; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Barber

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Balto City Hospt

(Address) Balto Md

15 Filed MAR 23 1927 Per

C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 3-19-27

17 I HEREBY CERTIFY, That I attended deceased from 3-5, 1927, to 3-19, 1927, that I last saw alive on 3-19, 1927 and that death occurred, on the date stated above, at 5.35 P. m.

The CAUSE OF DEATH* was as follows:

General Paralysis of Insane

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Luetic Infection

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Serological

(Signed) Wm. H. Crum, M. D.

, 19 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion

Date of Burial Mar 23 1927

20 UNDERTAKER Lauer & Whaley

ADDRESS 306-308 Myrtle Ave

IF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

10-002

E 20461 REGISTERED NO. E 20461

1-PLACE OF DEATH

City of BALTIMORE: (No. 1200 Longwood St., 16-67 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Esther J. Hertz

(a) RESIDENCE NO. 1200 Longwood St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of David E. Hertz,

6 DATE OF BIRTH (month, day, and year) December 29, 1895

7 AGE

| Years | Months | Days | IF LESS than I day hrs. or min.. |
|---|---|---|---|
| 31 | 2 | 21 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Martin Shirk

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Ida Krebs

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Pennsylvania

14 Informant David E. Hertz,

(Address) 1200 Longwood Street

15 Filed MAR 23 1927 19 C. HAMPSON JONES, M. D. Registrar

Per RK

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from March 17, 1927, to March 22, 1927, that I last saw her alive on March 22, 1927, and that death occurred, on the date stated above, at 1.05 p m.

The CAUSE OF DEATH* was as follows:

Acute Toxic Nephritis

Arteriosclerosis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

3-22-1927 (Address) 709 North Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — Date of Burial Mar. 23 1927

20 UNDERTAKER Leopold Cook — ADDRESS 1003 Hollins St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

# E 20462 HEALTH DEPARTMENT—CITY OF BALTIMORE E 20462

## CERTIFICATE OF DEATH.

90 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2121 E. Lombard ST. 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Linon Taylor

(a) RESIDENCE No. 2121 E Lombard ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? 38 yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Taylor

6 DATE OF BIRTH (month, day, and year) [illegible]

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 55 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Aaron Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Lena Taylor

(Address) 2121 E Lombard St

15 FILED MAR 23 1927, 19 Per C. HAMILTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/22 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov. 12, 1926, to March 22, 1927, that I last saw him alive on March 22, 1927, and that death occurred, on the date stated above, at 8:30 a m

The CAUSE OF DEATH* was as follows:

Chronic myocarditis
chronic Bronchitis
arterio Sclerosis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 2

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) N.A. Michelson, M. D.

March 22, 1927 (Address) 2230 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Cemetery

DATE OF BURIAL 3/23 1927

UNDERTAKER Jack Levin

ADDRESS 1429 Bond St

IMPORTANT See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 20463

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

11-001

E 20463

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 527 N. Belnord St., 6-10 Ward)

2-FULL NAME Norma Anna Frazier

(a) RESIDENCE NO. 527 N Belnord St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 6 — 1925

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 2 | 2 | 13 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Harry Frazier

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto

12 MAIDEN NAME OF MOTHER Josephine Trabuty

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto

14 Informant Harry Frazier

(Address) 527 N Belnord Ave

Filed MAR 23 1927 HAMPSON JONES, M. D.

Per ..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-19 19 27

17 I HEREBY CERTIFY, That I attended deceased from 3-8 19 27 to 3-19 19 27

that I last saw h alive on 3-19 19 27

and that death occurred, on the date stated above, at 7:30 A.M.

The CAUSE OF DEATH was as follows:

Influenza

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Fred Reynolds M. D.

3-21, 19 27 (Address) 800 N Wolfe Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem. Date of Burial March 23 1927

20 UNDERTAKER Jos. J. Herrabon ADDRESS 1564 N. Luzerne

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20464

## CERTIFICATE OF DEATH.

31 E 20464

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1258 E. North Av. ST.; 9-18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edgar Allen Ashton

(Residence in Baltimore: No. 1258 E. North Av. St.; 38 yrs., mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ....., (Month) (Day) 1889. (Year)

7-AGE, 38 yrs. mos. ds.

If LESS than 1 day, ....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Trader in Comp
(b) General nature of industry, business, or establishment in which employed (or employer) Beer Route #3

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Walter Edward Ashton

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Amelia C. Ramsel

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter E. Ashton

(Address) 1258 E. North Ave

15-

Filed ....., 191.... C. HAMPSON JONES, M. D.

APR 23 1917 For ..... Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 21, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 16 1916, to March 21 1917, that I saw him alive on March 20 1917, and that death occurred, on the date stated above, at 4.40 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Hugh Forsythe M. D.

3/22, 1917. (Address) 424 E. North Av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cemetery DATE OF BURIAL, 3.23., 1917

20-UNDERTAKER George J. Ruth ADDRESS 1738 Harford ave

Important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20465

## CERTIFICATE OF DEATH.

E 20465

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1509 Riggs Ave ST. 16-22 WARD)

2-FULL NAME Mary Magdalene Mackel

(a) RESIDENCE NO. 1509 Riggs Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 15 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | Col | |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 3-26

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 1 | 3 4 | 18 16 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ddo

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Howard Marshall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Beatrice Haynie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Howard Marshall

(Address) 1509 Riggs Ave

15 Filed MAR 23 1927 19

C. HAMILTON JONES, M. D.

Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 21 1927

17

I HEREBY CERTIFY, That I attended deceased from Mar. 17 1927 to Mar. 21 1927

that I last saw he alive on March 21 1927

and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs mos 4 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs mos 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr E W Leonard M. D.

3-22 1927 (Address) 708 Custer St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL Mch 25 1927

20 UNDERTAKER Sam H Grace Sons

ADDRESS Monument

CAUSE OF DEATH must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20466

## CERTIFICATE OF DEATH.

101-601

E 20466

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1911 W. Mulberry ST. 20-27 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Dunnor

(Residence in Baltimore: No. 1911 W. Mulberry St.: 43 yrs. 0 mos. 4 da.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, [redacted] Single (Write the word.)

6-DATE OF BIRTH, March 16, 1884 (Month) (Day) (Year)

7-AGE, 43 yrs. 0 mos. 4 da. If LESS than 1 day, ....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Printer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Charles Dunnor

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Carrie Mantlo

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carrie Mantlo

(Address) 1911 W. Mulberry St

15- Filed MAR 3 1927, 191.... HAMILTON JONES, M. D. Registrar.

Per ....

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 24, 1927 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 16 1927, to March 24 1927, that I saw h[illegible] alive on March 20 1927, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ....yrs. ....mos. 7 da.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) ....yrs. ....mos. 1 da.

(Signed) B. Kinder M. D.

3-21-, 1927 (Address) 2396 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....da. In the State ....yrs. ....mos. ....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, BALTIMORE CEM — DATE OF BURIAL, Mar 26, 1927

20-UNDERTAKER Robert Brookerson — ADDRESS Calhoun & Hollins

Important. See instructions on back of certificate. Information as to OCCUPATION is very

Spec.—1-12-23—M&T—500 Bks.

E 20467 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

38 E 20467
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 626 N Ede ST. 5-8 WARD)

2-FULL NAME Edward Robinson

(a) RESIDENCE NO. 626 N. Eden ST. WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 15 Months How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | C | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4.9.1878

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 48 | 11 | 12 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Presser
(b) General nature of industry, business, or establishment in which employed (or employer) Tailor Shop
(c) Name of employer ? Cooper

9 BIRTHPLACE (city or town) (State or country) Carlington S.C.

PARENTS

10 NAME OF FATHER Jack Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Buford S.C.

12 MAIDEN NAME OF MOTHER Mary Murray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S.C.

14 Informant Jack Robinson
(Address) 626 N. Eden

15 Filed MAR 23 1927 C. HAMILTON JONES, M. D. Registrar
Par

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 21 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar. 19, 1927, to Mar 21, 1927, that I last saw him alive on Mar 21, 1927, and that death occurred, on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia (duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Acute Myocarditis (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Phy. Exam

(Signed) W. L. Berry, M. D.

, 19 (Address) 1520 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury, County — DATE OF BURIAL 3/23 1927

20 UNDERTAKER Byron Wright — ADDRESS 1218 McCulloh

TION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 20468

100-001

E 20468

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2227 Lamely St 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Simmons

(a) RESIDENCE NO. 2227 Lamely St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divoreed, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divoreed
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) August ~~March~~ 22 1926

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..hrs. or ..min.. |
|---|---|---|---|---|
| | | 7 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~~Child~~

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Wm Simmons

11 BIRTHPLACE OF FATHER (City or town) Baltimore

(State or country)

12 MAIDEN NAME OF MOTHER Lucy Slakum

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country)

14 Informant William Simmons

(Address) 2227 Lamely

15 Filed AR 23 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/22 1927

17 I HEREBY CERTIFY, That I attended deceased from 3/15 1927, to 3/22 1927, that I last saw h~~e~~r alive on 3/21 1927, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobular
Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Physically

(Signed) Samuel Dorsch M. D.

, 19 27 (Address) 328 East St

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

Date of Burial Mar 24 1927

20 UNDERTAKER John Ellicot

ADDRESS 1508 Orleans St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20469

## CERTIFICATE OF DEATH.

11-001

E 20469

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1933 Eastern Ave 4 Ward)

2-FULL NAME Abolonia Grzelecki

(a) RESIDENCE NO. 1933 Eastern Ave St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Grzelecki

6 DATE OF BIRTH (month, day, and year): Unknown 1876

7 AGE: Years: 51 | Months: | Days: | IF LESS than 1 day.....hrs. or.....min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer): 03

(c) Name of employer: at Home

9 BIRTHPLACE (city or town): _____

(State or country): Poland

PARENTS

10 NAME OF FATHER: Malanowski

11 BIRTHPLACE OF FATHER (city or town): _____

(State or country): Poland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): _____

(State or country): Poland

14 Informant: Joseph Grzelecki

(Address): 1933 Eastern

15 Filed MAR 23 1927 19____ C. HAMPSON JONES, M. D.

By _____ Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

March 20. 1927

17 I HEREBY CERTIFY, That I attended deceased from 3/17, 1927, to 3/20, 1927

that I last saw h[illegible] alive on _____, 19 27

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Congestion of the Lungs

(duration) ____ yrs. ____ mos. 2 ds.

CONTRIBUTORY (Secondary) La Grippe

(duration) ____ yrs. ____ mos. 3 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. G. Friedman M. D.

Mar. 26, 19 27 (Address) 1918 Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — Date of Burial: Mch 24 19 27

20 UNDERTAKER: E. W. Ozazewski — ADDRESS: 1932 Eastern Ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 20470

E 20470 REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 818 Somerset St. 1014 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie A. Hernsing

(a) RESIDENCE NO. 818 Somerset St. 10 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 29 yrs. 4 mos. 15 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married. |

5a If married, widowed, or divorced HUSBAND of Mrs. Harry Hernsing. (or) WIFE of

6 DATE OF BIRTH (month, day, and year) November 7 1897

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min.. |
|---|---|---|---|---|
| | 29 | 4 | 15 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER John J. Hanlon

11 BIRTHPLACE OF FATHER (City or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Marie Greveldinger

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Mr. John J. Hanlon (Address) 1535 N. Dolphin St.

15 Filed MAR 23 1927 C. HAMPSON JONES, Registrar M. D.

Per RK

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 4 1926 to March 20 1927.

that I last saw h.. alive on March 29 1927.

and that death occurred, on the date stated above, at 5:30 a. m.

The CAUSE OF DEATH* was as follows: Tuberculosis

(a) Pulmonary (Hemorrhage)

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. A. Hornstein, M. D.

(Address) 733 Arlington St

*State the Disease Causing Death, or In deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Holy Redeemer, Cemetery — Date of Burial March 25 1927

20 UNDERTAKER Henry Hoeck Sons — ADDRESS 3016 Eager St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20471

E 20471

## CERTIFICATE OF DEATH.

101-00

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Roland Ave. near Cold Spring Lane Kirkleigh Villa St. 57-53 Ward)

2-FULL NAME Emma Atlee Coghlan

(a) RESIDENCE NO. Kirkleigh Villa St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

3a If married, widowed, or divorced (or) WIFE of Richard Coghlan

6 DATE OF BIRTH (month, day, and year) 1846

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 81 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER James C. Atlee

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah S. Jones

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14

Informant Mrs. James J. Carroll

(Address) Latrobe Apartments.

Filed MAR 23 1927 C. HAMPSON JONES, M. D.

Per RH Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mond March 21st 1927

17

I HEREBY CERTIFY, That I attended deceased from March 12th, 1927, to March 21st, 1927, that I last saw h.cy alive on March 21st, 1927, and that death occurred, on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. 9 mos. 14 ds.

CONTRIBUTORY (Secondary)

Pleurisy with effus (duration) yrs. mos. 14 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam + course of disease

(Signed) Sydenham R. Clarke, M. D.

, 19 (Address) Roland Park Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery Date of Burial 3/24 1927

20 UNDERTAKER Chas. J. Evans & Son ADDRESS 118 N. Mt. Royal Ave

OF DEATH in plain terms, so that it may be very important. See instructions on back of

Spec—12-23-21—E.B.R.S.—400 Bks.

E 20472

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

4/E 20472

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2001 Edmondson St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret A. Dorsey

(a) Residence No. 2001 Edmondson St. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 1 mos. 20 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-~~Single~~, Married, ~~Widowed, or Divorced,~~ (Write the word.) Married

5a-If married, ~~widowed, or divorced~~ ~~HUSBAND of (or)~~ WIFE of George Dorsey

6-DATE OF BIRTH (month, day and year) Feb 1st 1857

7-AGE. 70 yrs. 1 mos. 20 ds. If LESS than 1 day, ....hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (City or town) Baltimore, Md

(State or Country)

PARENTS.

10-NAME OF FATHER Richard Lee

11-BIRTHPLACE OF FATHER (city or town) Baltimore, Md

(State or Country)

12-MAIDEN NAME OF MOTHER Martha Sands

13-BIRTHPLACE OF MOTHER (city or town) Baltimore, Md

(State or Country)

14-(Informant) Ella Dorsey

(Address) 2001 Edmondson St

15-Filed MAR 23 1927, 19.. C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 24, 1927

17- I HEREBY CERTIFY, That I attended deceased from September 16 1926, to March 24, 1927.

that I last saw her alive on March 21, 1927.

and that death occurred, on the date stated above, at 3:00 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver & Rectum

(Duration) yrs. 6 mos. 5 ds

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. H. Isaacs, M. D.

. 19 (Address) 2414 Wilkens ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cemetery — DATE OF BURIAL Mar 24 19 27

20-UNDERTAKER. F. B. Hufnagel — ADDRESS 1605 W. Baltimore St

If plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20473

101-001 E 20473

## CERTIFICATE OF DEATH

REGISTERED NO. _____

1-PLACE OF DEATH

City of BALTIMORE: (No. 502 S. Potomac St. 1-2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leon Wisniewski,

(a) RESIDENCE NO. 502 S. Potomac St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? 47 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 2- 1879.

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min.. |
|---|---|---|---|---|
| | 47 | II | 20 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pipe moulder,

(b) General natore of industry, business, or establishment in which employed (or employer)

(c) Name of employer A. Weiskittel & Son Co.,

9 BIRTHPLACE (city or town)

(State or country) Poland,

PARENTS

10 NAME OF FATHER Thomas Wieniewski,

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Poland,

12 MAIDEN NAME OF MOTHER Unknown,

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland,

14 Informant Mrs. Stanislawa Wieniewski,

(Address) 502 S. Potomac Street

15 Filed _____, 19 _____ _____ Registrar

MAR 23 1927 C. HAMPSON JONES M.D.

Per _____

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927

March 22

17 I HEREBY CERTIFY, That I attended deceased from March 19, 1927, to March 22, 1927,

that I last saw h[illegible] alive on March 22, 1927

and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

R. Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) W. L. Burke, M. D.

March 1927 (Address) 3042 Hudson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| St. Stanislaus. | Mar 26 1927 |
| **20 UNDERTAKER** | **ADDRESS** |
| M. F. Sadowski. | 905 S. Ann St |

be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

20474

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

101-001

E 20474

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2425 Pfeister Court St. 1-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME MICHAEL LEWANDOWSKI,

(a) RESIDENCE NO. 2425 PFEISTER COURT St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? 43 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Stanislawa Lewandowski,

6 DATE OF BIRTH (month, day, and year) Sept., 22-1870.

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|---|
| | 56 | 5 | 0 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Street cleaning

(b) General nature of Industry, business, or establishment in which employed (or employer) Dept.,

(c) Name of employer Baltimore, City,

9 BIRTHPLACE (city or town)

(State or country) Poland,

PARENTS

10 NAME OF FATHER Joseph Lewandowski,

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Poland,

12 MAIDEN NAME OF MOTHER Unknown,

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland,

14 Informant Mrs. Stanislawa Lewandowski,

(Address) 2425 Pfeister Court,

15 Filed MAR 23 1927 G. HAMPSON JONES, M. D. Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/22 1927

17

I HEREBY CERTIFY, That I attended deceased from 3/12, 1927, to 3/22, 1927, that I last saw h[illegible] alive on 3/21, 1927, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Heart failure

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? N U Date of

Was there an autopsy? N O

What test confirmed diagnosis? Signs & symptoms

(Signed) Jay N Dulcost, M. D.

, 19 (Address) 1625 Bolton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus. Date of Burial Mar 26 1927

20 UNDERTAKER M. F. Sadowski. ADDRESS 902 N Gilmor St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20475

159-002

E 20475

## CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2010 Longwood St. 15-67 Ward)

2-FULL NAME Mrs. Schneider

(a) RESIDENCE NO. 2010 Longwood St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): _____

3a If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6 DATE OF BIRTH (month, day, and year): 3-22-27

7 AGE: Years ____ Months ____ Days 1 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: _____ old

(b) General nature of industry, business, or establishment in which employed (or employer): _____

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Oscar Schneider

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)

12 MAIDEN NAME OF MOTHER Dora Schneider

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant E L Goans (Address) 2010 Longwood St.

15 Filed _____ 19__ _____ Registrar

Per _____

MAR 23 1927 C. HAMPSON JONES, M.D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 3-23-27

17 I HEREBY CERTIFY, That I attended deceased from 3-22 19 27, to 3-23 19 27, that I last saw h alive on 3-22 19 27 and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Patent Foramen Ovale

_____ (duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) _____

_____ (duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

3/23/27 (Signed) Jay McCurdy, M. D.

19 (Address) 1400 N Calvert

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery Inc. Date of Burial 3-25 19 27

20 UNDERTAKER: George L. Schwartzbauer ADDRESS: Fulton Ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

E 20476

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

3 2 E 20476

1-PLACE OF DEATH Union Memorial Hospital REGISTERED NO. 21-43

City of BALTIMORE: (No. 33 2 + Calvert St St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nancy Ellen Heipoltz (Leipholtz)

(a) RESIDENCE NO. 19 W White St, Hamilton St. Balto Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. 9 mos. 23 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 29, 1921

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|---|
| | 5 | 9 | 23 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland (State or country)

PARENTS

10 NAME OF FATHER Michael Heipoltz

11 BIRTHPLACE OF FATHER (City or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Ruby Erskine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Michigan

14 Informant Hospital Records (Address)

15 Filed MAR 23 1927 HAMILTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22, 1927

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1927 to March 22, 1927 that I last saw h[illegible] alive on March 22, 1927 and that death occurred, on the date stated above, at 8 30 P m.

The CAUSE OF DEATH* was as follows:

Basilar meningitis (streptococcus pneumococcus)

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) otitis media right

(duration) yrs. 2½ mos. ds.

18 Where was disease contracted if not at place of death? 19 W White St

Did an operation precede death? no Date of

Was there an autopsy? yes (partial)

What test confirmed diagnosis? Clinical & laboratory tests

(Signed) Franklin Smith, Jr. M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery Date of Burial 3/25 1927

20 UNDERTAKER William Cook ADDRESS 502 E North Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12 23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E.20477

## CERTIFICATE OF DEATH.

100-001 ✓

E 20477
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Baltimore Gen. Hosp. St. 9-47 WARD)

2-FULL NAME Frank Green

(a) RESIDENCE NO. 705 (Usual place of abode) Chestnut Hill St. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 24y yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 13-96

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | | 7 | 10 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Maurice Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Rose Kern

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant (Address) G.B.G. Hosp. Reads

15 (Filed) MAR 23 1927 C. HAMPSON JONES, M. D. Registrar Per R.K.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/23 1927

17 I HEREBY CERTIFY, That I attended deceased from 3/4 1927, to 3/23 1927, that I last saw him alive on 3/23 1927, and that death occurred, on the date stated above, at 1.30 a m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Empyema

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3/22/27

Was there an autopsy?

What test confirmed diagnosis? Clinical & Path Exam

(Signed) Arnold Rogerson M. D.

(Address) G.B.G. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL 3/24 1927

20 UNDERTAKER William Cook — ADDRESS 502 E North

CAUSE OF DEATH must be given in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Dr Hall — 1631 E North Ave

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20478

## CERTIFICATE OF DEATH.

31

E 20478

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 521 East 38th St.) 9-47 (WARD)

2-FULL NAME Joseph A Espey

(a) RESIDENCE NO. 521 E 38th St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of)

6 DATE OF BIRTH (month, day, and year): Oct 6, 1871

7 AGE — Years: 55 Months: 5 Days: 15 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Electrician

(b) General nature of industry, business, or establishment in which employed (or employer): Oil

(c) Name of employer: Self.

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: William P Espey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Mary J Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: W E Thompson

(Address): 521 E 38th St

15 Date: 1927 C. HAMPSON JONES, M. D. Registrar

By: CRH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 21 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan-2- 1927 to Mch-21 1927.

that I last saw him alive on Mch-21 1927

and that death occurred, on the date stated above, at 4-500 m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Bronchitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? NV Date of

Was there an autopsy? NV -

What test confirmed diagnosis? X Ray

(Signed) E Gill Hall, M. D.

Mch 22 1927 (Address) 1631 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore — DATE OF BURIAL: March 24 1927

20 UNDERTAKER: H W Cook — ADDRESS: 517 E North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

23 1927

Spec.–7-17-26—A Co.—200 Bks.

Dr Jas. R Kirby 1123 Baptist Grave

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20479

## CERTIFICATE OF DEATH

31 E 20479

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 634 Indiana Ave. Ward 25-32)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas J Goldhammer

(a) RESIDENCE NO. 634 Indiana Ave. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S. if of foreign birth yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Bessie Goldhammer

6 DATE OF BIRTH (month, day, and year): March 5 1882

7 AGE: Years 45 Months 0 Days 17 23

If LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Press 86

(b) General nature of industry, business, or establishment in which employed (or employer): Operator

(c) Name of employer: Tin Dec. Co.

9 BIRTHPLACE (city or town): Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER: John Goldhammer

11 BIRTHPLACE OF FATHER (City or town): Baltimore Md

(State or country)

12 MAIDEN NAME OF MOTHER: Anna Cook

13 BIRTHPLACE OF MOTHER (city or town): Baltimore Md

(State or country)

14 Informant: Bessie Goldhammer (Address) 634 Indiana Ave

15 Filed R 23 1927 C. HAMPSON JONES, M. D. Registrar

Per OR 14

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 22 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1926, to March 21 1927, that I last saw him alive on March 21 1927, and that death occurred, on the date stated above, at 3 15 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted —

if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Course X Ray Sputum

(Signed) Jas R Kirby, M. D.

March 23, 1927, (Address) 1123 Baptist Lane

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem. Date of Burial March 25 1927

20 UNDERTAKER: William Cook ADDRESS 5046 Reisterstown Rd

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20480

## CERTIFICATE OF DEATH

45

E 20480

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3037 Eastern ave. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Krutsch

(a) RESIDENCE NO. 3037 Eastern ave. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 51 yrs. 7 mos. 10 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug - 13 - 1875

| 7 AGE | Years | Months | Days | IF LESS than 1 day ... hrs. or ... min.. |
|---|---|---|---|---|
| | 51 | 7 | 10 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sort maker

(b) General nature of industry, business, or establishment in which employed (or employer): 580

(c) Name of employer: Otto Duncker

9 BIRTHPLACE (city or town): Baltimore

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Frank Krutsch

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Oberlander

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: Lillie Garrison

(Address) 21 N. Hare st

Filed ... 19 ... C. HAMPSON JONES, M. D. Registrar

For RKS

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 Mar - 23 - 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr - 1 . 1926 to Mar 23 . 1927.

that I last saw him alive on Mar 22 1927

and that death occurred, on the date stated above, at 12:30 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

over a year

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY Met. of liver.

(Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Consultation of Hosp

(Signed) Dan'l Deaver, M. D.

3/23, 1927 (Address) 122 W Lee st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn — Date of Burial: Mch 25 1927

20 UNDERTAKER: H. Cole — ADDRESS: 502 E. Fayette

MAR 23 1927

WARNING.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20481

## CERTIFICATE OF DEATH.

E 20481

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1110 First St. Morrell Park Ward.

2-FULL NAME Richard H. Conway.

(a) RESIDENCE NO. 1110 First St. Morrell Park Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | white. | Married |

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary E. Conway nee O'Connor

6 DATE OF BIRTH (month, day and year) March 17. 1852

| 7 AGE Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|
| about 75 | | 3 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired. 061

(b) General nature of industry, business, or establishment in which employed (or employer) Policeman.

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Richmond Va.

PARENTS

10 NAME OF FATHER, Richard Conway

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland.

14 Informant Mrs Mary E. Conway.

(Address) 1110 First St Morrell Park

15 Filed 3/21 1927 C. HAMPSON JONES, M. D. Registrar

Per R H H

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) 19

Mch 20 1927

17

I HEREBY CERTIFY, That I attended deceased from Jany 1, 1927, to Jany 20, 1927, that I last saw h.. alive on Jany 19, 1927, and that death occurred, on the date stated above, at 10-20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal Nephritis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) [illegible], M. D.

3/21 1927 (Address) 232 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem. Date of Burial 3/24/1927

20 UNDERTAKER John F. Cowpen & Son ADDRESS Per F. J. Cowpen 901 Hollins St.

...should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state ... OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION ... very important. See instructions on back of certificates.

E 20482

# HEALTH DEPARTMENT--CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 20482

44

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 424 North mount St. 19-27 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Susan Norris

(Residence in Baltimore: No. 424 N Mount. St. 25 yrs. mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 SINGLE, MARRIED WIDOWED OR DIVORCED (If single, write the word): Widow

6 DATE OF BIRTH: Aug (Month) 1 (Day), 1860 (Year)

7 AGE: 66 yrs. 7 mos. 21 ds. If LESS than 1 day, ..... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Snow Hill Maryland

PARENTS

10 NAME OF FATHER: Perry Kennard

11 BIRTHPLACE OF FATHER (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Do not know

13 BIRTHPLACE OF MOTHER (State or country): Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Catherine Campbell

(Address) 424 N. Mount St

15

Filed C. HAMPSON JONES, M. D. REGISTRAR

By RKD

MAR 27 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: March (Month) 21 (Day), 1927 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 7, 1927. to. March 21 1927.

that I saw her alive on March 19, 1927.

and that death occurred, on the date stated above, at 5.30 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Oesophagus

(Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY)

(Duration) Several months

(Signed) Frances A. Carbaugh M. D.

Mar 23, 1927. (Address) 210 Madison ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: New Cathedral cem

DATE OF BURIAL: Mar 24, 1927

20 UNDERTAKER: Mrs R A Elliott

ADDRESS: 1725 Ashland ave

S. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20483

## CERTIFICATE OF DEATH.

129 E 20483

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2013 S. 14th St. 26-36 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate Smith

(a) RESIDENCE NO. 2013 S. 14th St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: Frank H. Smith

6 DATE OF BIRTH (month, day, and year): Nov 28/63

7 AGE — Years: 63 — Months: 3 — Days: 22 20 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Carl Wetzel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Frank H. Smith 2013 S. 14th St.

15 MAR 23 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 20/27

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1926 to March 20, 1927, that I last saw h.....r alive on March 20, 1927, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) Gradual yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) Gradual yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Horace B. Tucker, M. D.

3/22, 1927 (Address) 3158 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity — Date of Burial: 3/24 1927

20 UNDERTAKER: Philip Herwig — ADDRESS: 2016 Adams St

Filled in by Undertaker. Every question should be carefully answered. Information should be stated EXACTLY. PHYSICIANS should be careful to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 20484

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

164

E 20484

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2014 E. Madison St. 7-13 Ward)

2-FULL NAME Sophia E. Frederick

(a) RESIDENCE NO. 2014 E. Madison St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced, ~~HUSBAND of~~ (or) WIFE of late Chas. Frederick

6 DATE OF BIRTH (month, day, and year) July 10/44

7 AGE: Years 82 | Months 8 | Days 12 | If LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Balto

PARENTS

10 NAME OF FATHER Jacob Kinzle

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Pa.

14 Informant Chas. Frederick

(Address) 1701 E. 29th St.

15 Filed _____ 19 _____ Registrar

C. HAMPSON JONES, M. D.

Per _____

2 3 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 Mar. 22/27

17

I HEREBY CERTIFY, That I attended deceased from March 18 1927 to March 22, 1927, that I last saw h-er alive on March 21, 19 ____, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ____ yrs. ____ mos. 4 ds.

CONTRIBUTORY (Secondary) Inanition

(duration) ____ yrs. ____ mos. 4 ds.

18 Where was disease contracted? none

If not at place of death?

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? _____

(Signed) Thomas J. Emmas, M. D.

, 19 (Address) 1025 N. Wolfe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn — Date of Burial 3/25 1927

20 UNDERTAKER: Philip Hennig — ADDRESS 2016 Orleans St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 20485

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 20485

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 425 N. Stricker St.) (WARD) 14-27

REGISTERED NO. 89

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Osborn

(a) RESIDENCE NO. 425 N. Stricker ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | colored | widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Osborn

6 DATE OF BIRTH (month, day, and year) unknown

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs. or min. |
|---|---|---|---|---|
| | 60 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Alfred Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Grace Bell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Annie E Brown

(Address) 425 N. Stricker St

15 Filed MAR 23 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 22 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 20, 1927, to Mar 22, 1927, that I last saw her alive on Mar 22, 1927, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Ralph E. Wilson M. D.

3-27 1927 (Address) 1706 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [redacted] Woodlawn Cemetery DATE OF BURIAL Mar 27, 1927

20 UNDERTAKER Mrs. Katie R. Williams ADDRESS 322 N. Schroeder St

mation should be carefully supplied. AGE should be stated EXACTLY. Every item of information is important. See instructions on back of certificates.
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20486

## CERTIFICATE OF DEATH.

101-001

E 20486

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals Ward) B-5

2-FULL NAME Mary Maltizzi

(a) RESIDENCE NO. 24 S Exeter St. _____ Ward _____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | white | married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Harry Maltizzi

6 DATE OF BIRTH (month, day, and year) unknown

| 7 AGE | Years | Months | Days | If LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 29 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer at home

9 BIRTHPLACE (city or town) Salt Lake City

(State or country)

PARENTS

10 NAME OF FATHER Robt. Muller

11 BIRTHPLACE OF FATHER (city or town) unknown

(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown

(State or country)

14 Informant Harry Maltizzi

(Address) 245 Exeter

15 Filed C. HAMPSON JONES, M. D.

MAR 23 1927 Per _____ Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 21 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ____ yrs. ____ mos. 4 ds.

CONTRIBUTORY (Secondary) Anemia & Emaciation

(duration) ____ yrs. ____ mos. One ds.

(Signed) James H. Hinton, M. D.

(Coroner)

3-23-1927 (Address) 7002 Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death Salt Lake City Hosp yrs. ____ mos. 2 hrs In the State yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? 245 Exeter

Former or usual residence 245 Exeter

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem. Date of Burial 3/23 1927

20 UNDERTAKER J. E. Talley & Son ADDRESS 1318 Light St.

don should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20487

## CERTIFICATE OF DEATH.

66 E 20487

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hosp St., 4-7 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm Monahan ?

(a) RESIDENCE NO. [illegible] St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | W | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

| 7 AGE Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|
| About 42 | [illegible] | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 087

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant

(Address)

15 Date 1927 C. HAMPSON JONES, M. D.

By _____ Registrar

1190 MORGUE.

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 10 27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

* Acute alcoholism
Fractured skull
Contusion of brain

(duration) [illegible] yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) W. J. Kelly, M. D.
(Coroner)

March 17, 1927 (Address) 407 Fidelity Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ..... mos., ..... ds. In the State ..... yrs., ..... mos., ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

UNIVERSITY OF MARYLAND MAR 23 1927

Commissioner Health.

This is a permanent record. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Blks.

# E 20488

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

56 E 20488

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1421 McElderry St. 5-9 Ward)

2-FULL NAME Baby Wood

(a) RESIDENCE NO. 1421 McElderry St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | aa | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 5, 1927

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | — | — | 16 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — (Do)

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER William Wood

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Silvia Cosby

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14

Informant

(Address)

Filed MAR 23 1927 C. HAMPSON JONES, M. D.

By Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21, 1927

17 I HEREBY CERTIFY, That I attended deceased from March 5 1927, to March 21, 1927, that I last saw he alive on March 21, 1927, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows: Marasmus and Rickets with malnutrition

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Premature Birth (7 Months)

(duration) yrs. mos. 16 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) L. F. Hall, M. D.

, 19 (Address) 426 E 23rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND Date of Burial MAR 23 1927

20 UNDERTAKER General Asst. Health. ADDRESS

1191

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20489 (1927) — CERTIFICATE OF DEATH. — X84 E 20489

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 19 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Sharpesnek

(a) RESIDENCE NO. 407 E. Main St. Uniontown Pa. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? 1905

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 22 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Pa.

PARENTS

10 NAME OF FATHER David Sharpesnek

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Martha Seder

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

C. HAMPSON JONES, M. D. Registrar

MAR 23 1927

Per RRH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 March 23, 1927

17 I HEREBY CERTIFY, That I attended deceased from March 11, 1927, to March 23, 1927, that I last saw h.im alive on March 23, 1927, and that death occurred, on the date stated above, at 8.35 a.m.

The CAUSE OF DEATH* was as follows:

Brain Tumor — (benign)

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) broncho pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of March 19, 1927

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) George G. Finney M. D.

3/23/1927 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Connellsville Pa Cassandelle Pa — Date of Burial 3/23/27

20 UNDERTAKER Connellsville — ADDRESS 224 Broadway

Joseph Adams

tion should be careful supplied. AGE should be stated EXACTLY. PHYSICIANS should state CA OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIO very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

E 20490

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

90 E 20490

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 128 S. Dulaney St., 16-2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thy A Mayhock

(a) RESIDENCE NO. 128 S. Dulaney St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. 2 mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): married

5a ~~If married, widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Emma L. Mayhock

6 DATE OF BIRTH (month, day, and year) June 4- 1853

7 AGE: Years 73 Months 9 Days 18 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) House of

(c) Name of employer 015

9 BIRTHPLACE (city or town) .....

(State or country) Maryland

PARENTS

10 NAME OF FATHER Julius W. Mayhock

11 BIRTHPLACE OF FATHER (City or town) .....

(State or country) Germany.

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) Germany

14 Informant Emma L. Mayhock

(Address) 128 S. Dulaney St

15 Filed 2 3 1927 C. HAMPSON JONES, M. D. Registrar

Per .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22- 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec. 22 1926 to March 22 1927.

that I last saw him alive on March 21 1927.

and that death occurred, on the date stated above, at 12 A m.

The CAUSE OF DEATH* was as follows:

Chr. Myo-Cardits

(duration) 3 mos. yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Circulation

(Signed) Frank A. Hearn, M. D.

March 23 1927 (Address) 3244 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Mt Carmel Cem. March 27 1927

20 UNDERTAKER Gladh & Shuster — ADDRESS 22 W Pratt

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 20491 — E 20491

13-51 31

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3212. Cedar Avenue. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vida M. Buchman.

(a) Residence No. 3212. Cedar Avenue. St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS.

| 3-SEX. | 4-COLOR OR RACE. | 5-Single, Married, Widowed, or Divorced. (Write the word.) |
|---|---|---|
| female. | white. | married. |

5a-If married, widowed, or divorced XXXXXXXXXX WIFE of Wm. F.Buchman.

6-DATE OF BIRTH (month, day and year) Sept.28/1906.

7-AGE. 20. yrs. 5 mos. 24 ds. If LESS than 1 day, ....hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House wife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Balto.City. (State or Country) Maryland.

PARENTS.

10-NAME OF FATHER, Jacob A. Hackley.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), West,Virginia.

12-MAIDEN NAME OF MOTHER, Mary C. Brown.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland.

14-

(Informant) Jacob A.Hackley.

(Address) 3212.Cedar Avenue.

15-

Filed MAR 23 1927 C. HAMPSON JONES, M. D. Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) MAR. 22/1927.

17- I HEREBY CERTIFY, That I attended deceased from Jan 15, 1927 to MAR 22, 1927.

That I last saw her alive on MAR 22, 1927,

and that death occurred, on the date stated above, at 7- P m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Tuberculosis

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) C. H. Jones M. D.

3-23, 1927 (Address) 800 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19-PLACE OF BURIAL, CREMATION OR REMOVAL. | DATE OF BURIAL. |
|---|---|
| St.Marys cem.(Hampden) | MAR 25/1927. |

| 20-UNDERTAKER. | ADDRESS |
|---|---|
| J.Walter Davis | 3307.Paine,St. |

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

E 20492

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20492

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [illegible] St. 16-37 Ward)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Graham Trull

(a) RESIDENCE NO. [illegible] St. [illegible] Ward [illegible]

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1845

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 82 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Collector

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town)

(State or country) England

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) England

14 Informant BALTIMORE CITY HOSPITALS

(Address) Records

15 1927 19 C. HAMPSON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22 1927

17

I HEREBY CERTIFY, That I attended deceased from August 20, 1925, to March 22, 1927, that I last saw him alive on March 22, 1927, and that death occurred, on the date stated above, at 3:10 P m.

The CAUSE OF DEATH* was as follows:

Senility

Chronic Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? General & Laboratory

(Signed) C. Hampson Jones, M. D.

March 31 1927 BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Loudon Park Cem | Mar. 27 1927 |
| 20 UNDERTAKER Harry W. Ehlen | ADDRESS 1944 W. North Ave |

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAU... OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIO... very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20493

## CERTIFICATE OF DEATH

E 20493

REGISTERED NO. 38-66

1-PLACE OF DEATH

City of BALTIMORE: (No. Forest Ave.nr.Windsor Mill Rd. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Sophronia Lilly

(a) RESIDENCE NO. Thurmont, Md. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1½ mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | White | Widowed |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)
March 19, 1854

| 7 AGE | Years | Months | Days | IF LESS than 1 day ...hrs. or ...min.. |
|---|---|---|---|---|
| | 73 | xxx | 3 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Frederick County, Md.

PARENTS

10 NAME OF FATHER Jacob Root

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Frederick County, Md.

12 MAIDEN NAME OF MOTHER Eliza Ann Zeigler

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Montgomery Co., Md.

14 Informant Mrs. C. H. Spurrier

(Address) Forest Ave.nr. Windsor Mill

15 Filed MAR 23 1927 C. HAMPSON JONES, M. D. Registrar

Per RRS.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19
March 22, 1927

17 I HEREBY CERTIFY, That I attended deceased from Mch 15 1927 to Mch 22 1927

that I last saw her alive on Mch 21 1927

and that death occurred, on the date stated above, at 7.20 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) A. C. Smith M. D.

3-25 1927 (Address) 4509 Liberty Heights Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Frederick, Md. Mt. Olivet Cemetery, Date of Burial Mar. 25, 27

20 UNDERTAKER Chas. H. Cook ADDRESS 1002 Eutaw St.

GIVE PLAINLY, WITH ... INK—THIS IS A PERMANENT RECORD. Every item ... for ... tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CONDITION is very important. See instructions on back of certificates.

Burial 37 S. Stricker

Spec.—7-17-26—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20494

## CERTIFICATE OF DEATH

100,001

E 20494

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 712 Lemmon Lane St.) Ward) 20-69

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul Albert Brandt—

(a) RESIDENCE NO. 712 Lemmon Lane St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar 31 1926

7 AGE: Years 9 Months 21 Days — IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town)

(State or country) Balt.

PARENTS

10 NAME OF FATHER Paul A. Brandt—

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Balto—

12 MAIDEN NAME OF MOTHER Ethel MacConnell

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Paul A. Brandt—

(Address) 712 Lemmon Lane

15 [illegible] C. HAMPSON JONES, M. D.

Per [illegible] Registrar

MAR 23 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 27 Mch 22

17 I HEREBY CERTIFY, That I attended deceased from Mar 15, 1927, to Mar 22, 1927,

that I last saw him alive on Mar 21, 1927,

and that death occurred, on the date stated above, at 5.30 A. m.

The CAUSE OF DEATH* was as follows:

Broncho - Pneumonia (acute)

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) Anthony V. Buchheas, M. D.

3/22, 1927 (Address) 37 S. Stricker St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Interment Mch 24 — Date of Burial 3/24 19

20 UNDERTAKER: H. W. Cole — ADDRESS [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 20495

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20495

## CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] Ward 23-4)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Smith

(a) RESIDENCE NO. 1340 W. North Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1883

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 44 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Auto Painter

(b) General nature of industry, business, or establishment in which employed (or employer) 05

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Ill.

PARENTS

10 NAME OF FATHER William Smith

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ill

12 MAIDEN NAME OF MOTHER Catharine Eck

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant

(Address) [redacted]

BALTIMORE CITY HOSPITALS

MAR 23 1927 19 C. HAMPSON JONES, M. D.

Per Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 1927

17

I HEREBY CERTIFY, That I attended deceased from February 1. 1927, to March 19, 1927, that I last saw him alive on March 19, 1927, and that death occurred, on the date stated above, at 145 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Chronic Myocarditis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. mos. ? ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? general & laboratory

(Signed) R. Hampson Smith, M. D.

Mch 20 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease—(causing the death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

Date of Burial 3/24 1927

20 UNDERTAKER H. Staley & Sons

ADDRESS 1918 Eighth St.

tion should be carefully supplied, AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

THIS IS A PERMANENT RECORD.

Spec. -7-17-26—A Co.—200 Bks.

E 20496

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

101-001

E 20496

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1935 Aliceanna St St. 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Milton Siedlecki

(a) RESIDENCE NO. 1935 Aliceanna St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 10 1926

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min.. |
|---|---|---|---|---|
| | 1 | | 12 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto Md

PARENTS

10 NAME OF FATHER Adolf Siedlecki

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Lachowski

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Adolf Siedlecki

(Address) 1935 Aliceanna St

15 Filed MAR 23 1927

16 C. HAMPSON JONES, M. D. Registrar

Per RKH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23 1927

17 I HEREBY CERTIFY, That I attended deceased from Mch 15 1927 to Mch 23 1927

that I last saw h alive on Mch 23 1927

and that death occurred, on the date stated above, at 1205 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilat.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wellington Jones M. D.

19 (Address) 1 W. 23rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Holy Rosary Cem March 24 27

20 UNDERTAKER — ADDRESS

John M Weber 1503 Bank St

U. S.—WRITE PLAINLY, WITH UNFADING INK—This is a permanent record. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-19-21—M&T—1500 Bks.

E 20497

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20497

## CERTIFICATE OF DEATH.

143

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1401 Olem ST., 9-17 WARD)

2-FULL NAME Ellen Moyer

(a) RESIDENCE No. 1401 Olem ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 7 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | W | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John A Wagner

6 DATE OF BIRTH (month, day, and year) Aug 9 1903

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or min. |
|---|---|---|---|---|
| | 23 | 7 | 13 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER H Wagner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Eva Bradley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant John A Wagner

(Address) 1401 Olem Ave

15 MAR 23 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/21 — 1927

17 I HEREBY CERTIFY, That I attended deceased from 9/18 —, 1926, to 3/21 —, 1927

that I last saw he alive on 3/20 —, 1927

and that death occurred, on the date stated above, at 9:30 a m.

The CAUSE OF DEATH* was as follows:

Cardiac Collapse probably due to Thrombosis of Heart

(duration) — yrs. — mos. 1/2 hr.

CONTRIBUTORY (Secondary) Miscarriage

(duration) — yrs. — mos. 2 — ds.

18 Where was disease contracted if not at place of death? Maternity Hospital

Did an operation precede death? No Date of 12/20/26

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A Hutchinson, M. D.

, 19 (Address) 1340 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. DATE OF BURIAL: 3/24 1927

20 UNDERTAKER: Lipsett Recktenwald ADDRESS: 1111 E Eager St

mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20498

## CERTIFICATE OF DEATH.

x 44 ✓ E 20498

1-PLACE OF DEATH

REGISTERED NO._____

City of BALTIMORE: (JOHNS HOPKINS HOSPITAL St., 1-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. William Niven

(a) RESIDENCE NO. Moven, N.C St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1862

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 65 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer): 86

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) N. C.

PARENTS

10 NAME OF FATHER Duncan Niven

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant

(Address) JOHNS HOPKINS HOSPITAL

15 Filed MAR 23 1927, 19____ WM. HAMPSON JONES, M. D.

Registrar

Per MRH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23/27 19

17 I HEREBY CERTIFY, That I attended deceased from March 5 1926, to March 23, 1927,

that I last saw h. alive on 8:01 P.M., 1927,

and that death occurred, on the date stated above, at 8:02 P.M.

The CAUSE OF DEATH* was as follows: Cancer of stomach ?

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insuff

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Autopsy

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Walter Shorey, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Wakeslora N C — Date of Burial: 3/23/27

20 UNDERTAKER: Joseph Ahrens — ADDRESS: 22 Bura

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

THIS IS A PERMANENT RECORD. Every item

Spec.-7-17 26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 20499

## CERTIFICATE OF DEATH

E 20499

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 802 West Fayette St., (W-27) Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minna Strauzkiewicz

(a) RESIDENCE NO. 802 West Fayette St. 27th Ward 27th

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | white | Widow |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 10 1846

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|---|
| | 80 | 4 | 10 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER No Information

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER No Information

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Kuk Straus

(Address) 802 W Fayette St

15 Filed MAR 24 1927, 19

C. HAMPSON JONES, M. D.

Per R.H. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 21 19 27

17 I HEREBY CERTIFY, That I attended deceased from Mar 18, 19 27, to Mar 21, 19 27,

that I last saw h[illegible] alive on Mar 21, 19 27,

and that death occurred, on the date stated above, at 1 p. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(primary)

(duration) yrs. mos. 4 ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P.E.

(Signed) Homer L. Dodd, M. D.

3/24 19 27 (Address) 735 N. Fulton

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery Date of Burial March 19 27

20 UNDERTAKER C. D. Abernathy ADDRESS Elkton, Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

20500

## CERTIFICATE OF DEATH.

E 20500

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1016 Arlington Ave ST. 16-23 WARD)

2-FULL NAME Maria Griffin Murray

(a) RESIDENCE NO. 1016 Arlington Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Murray

6 DATE OF BIRTH (month, day, and year): Apr 10 1859

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 67 | 11 | 11 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): md

PARENTS

10 NAME OF FATHER: not known

11 BIRTHPLACE OF FATHER (city or town) (State or country): md

12 MAIDEN NAME OF MOTHER: not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): not known

14 Informant: Dora Gassaway

(Address) 1016 Arlington ave

15 Filed MAR 24 1927 Per R.C. Registrar

H. O. HARRISON JONES, M. D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 21st 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 26 1927 to Mar 21 1927

that I last saw h. alive on Mar 20th 1927

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 2 mos. ds.

CONTRIBUTOR (Secondary) Cerebral arteriosclerosis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Harry T. Brown M. D.

3/22 1927 (Address) 1916 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Star

DATE OF BURIAL: 3/24/27

20 UNDERTAKER: Samuel Brusley

ADDRESS 1258 Edmondson Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20501

1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

E 20501

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 207 E. Franklin Ave ST., 76 WARD)

2-FULL NAME Herman L. Kornick

(a) RESIDENCE: No. 207 E. Franklin ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clara Barth Kornick

6 DATE OF BIRTH (month, day, and year) Jan 16th 1850

| 7 AGE Years | Months | Days | If LESS than 1 day, ....hrs. or ....min. |
|---|---|---|---|
| 69 | 2 | 6. | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Proof Reader 63

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Bremmel & Heech

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Edward Kornick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Teresa

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Herman L. Kornick

(Address) 9 Aunsone Ave

15 Filed MAR 24 1927 C. HAMPSON JONES, M. D. Registrar

Per R.H.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22 1927

17 I HEREBY CERTIFY, That I attended deceased from Feby 1 1927 to March 22 1927, that I last saw h alive on March 21 1927, and that death occurred, on the date stated above, at 6 m.

The CAUSE OF DEATH* was as follows:

Chronic Asthma

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Senile Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph L. Volkmann M. D.

March 22 1927 (Address) 14 S. Howard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL March 25 1927

20 UNDERTAKER Frank V. Fipitone — ADDRESS 2015 E. Belt St

S. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 20502 100-001 E 20502

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1005 Woodyear St. 16-23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irene Henley

(a) RESIDENCE NO. 1005 Woodyear St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Robert Henley

6 DATE OF BIRTH (month, day, and year): August 15 1881

7 AGE: Years 45 Months 7 Days 8

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work

(b) General nature of industry, business, or establishment in which employed (or employer): Own

(c) Name of employer: self

9 BIRTHPLACE (city or town): Essex Co

(State or country): Va

PARENTS

10 NAME OF FATHER: Samuel Jackson

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Gloucester co. Va

12 MAIDEN NAME OF MOTHER: Martha Holmes

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Essex co. Va

14 Informant: Husband

(Address): 1005 Woodyear St.

15 Filed MAR 24 1927 By HAMPTON JONES M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: 3-23-27

17 I HEREBY CERTIFY, That I attended deceased from 3-22, 1927, to 3-23, 1927, that I last saw h.s alive on 3-23, 1927, and that death occurred, on the date stated above, at 10:20 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Bronchitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Hampton Saunders, M. D.

. 19 (Address) 1029 Stricker St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bowlegs Wharf Va

Date of Burial: March 24 1927

20 UNDERTAKER: Newell Carson

ADDRESS: Va ave.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Pretlow

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20503

100-004 20503

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 826 George St.: 17-16 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lucile Pretlow

(Residence in Baltimore: No. 826 George St.: yrs., mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)

6-DATE OF BIRTH, 1 (Month) 21 (Day), 1926 (Year)

7-AGE, 1 yrs. 2 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto city

PARENTS.

10-NAME OF FATHER, George N. Pretlow

11-BIRTHPLACE OF FATHER (State or Country), Hampton, Va.

12-MAIDEN NAME OF MOTHER Fannie Traynor

13-BIRTHPLACE OF MOTHER (State or Country), Richmond Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. W. Pretlow

(Address) 826 Geo. St

15-

Filed ....., 191.....

Registrar.

MAR 24 1927

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 3 (Month) 21 (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 3-17-27 191, to 3-21-27 191, that I saw her alive on " 191, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Bronchitis

(Duration) yrs. mos. 1 ds.

(Signed) F. M. Cardozo M. D.

3-22-27, 191... (Address) 1524 Druid Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem. DATE OF BURIAL, March 24/27

20-UNDERTAKER Hamil Easton ADDRESS 916 Druid

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20504

## CERTIFICATE OF DEATH.

129

REGISTERED NO. E 20504

1-PLACE OF DEATH

City of BALTIMORE: (No. 524 Dolphin St. St. 17-24 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H. Evans

(a) RESIDENCE NO. 524 Dolphin St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | colored | single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1901

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 26 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker's helper

(b) General nature of industry, business, or establishment in which employed (or employer) 003

(c) Name of employer unknown

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER John H. Evans

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Annie R Jones

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Annie R. Evans

(Address) 524 Dolphin St

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MAR 24 1927

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) jurors find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. 6 mos. .....ds.

(Signed) J. T. Hennessy M. D. (Coroner)

19 27 (Address) March 24 2502 Edmondson Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem Date of Burial March 24/1927

20 UNDERTAKER Daniel Easton ADDRESS 64 Ann

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

---

Spec.—12-9-25—A Co.—200 Bks.

Causey

Spec.—12-9-25—A Co.—200 Bks.

Cousey

# HEALTH DEPARTMENT—CITY OF BALTIMORE

20121 C

## CERTIFICATE OF DEATH.

31 E 20505

1-PLACE OF DEATH E 20505

REGISTERED NO.

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Zetharay Cousey

(a) RESIDENCE NO. 921 Hilden St. City Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1923

7 AGE: Years 4 | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md —

(State or country)

PARENTS

10 NAME OF FATHER James Cousey

11 BIRTHPLACE OF FATHER (city or town) Md —

(State or country)

12 MAIDEN NAME OF MOTHER Edwina Johnson

13 BIRTHPLACE OF MOTHER (city or town) Md —

(State or country)

14 Informant Records —

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 C. HAMPSON JONES, M. D. Registrar

Per —

MAR 24 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 22 1927

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1927, to March 22, 1927, that I last saw h alive on Mar. 22, 1927, and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) Tuberculosis Meningitis

(duration) ..... yrs. ..... mos. 1 wks.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? X Ray Spinal fluid

(Signed) Nemos D Corscadden, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — Date of Burial: Mar 25 1927

20 UNDERTAKER: Edward Bryan — ADDRESS 1631 Orleans St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 20506

## CERTIFICATE OF DEATH.

E 20506

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1720 N Carey St., 15-21 Ward)

2-FULL NAME Thomas Hall

(a) RESIDENCE NO. 1720 N Carey St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | Widower |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1858?

| 7 AGE Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|
| 69? | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va.

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant William Hall

(Address) 617 Orleans St

15 Filed....., 19.....

C. HAMPSON JONES, M. D.

Registrar

MAR 24 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 21 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 20, 1927, to Mar 21, 1927,

that I last saw h.. alive on Mar 21, 1927,

and that death occurred, on the date stated above, at 4:30 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY

(Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. William Lee, M. D.

3-22, 1927 (Address) 928 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — Date of Burial Mar 24 1927

20 UNDERTAKER Edward Bryan — ADDRESS 631 Orleans St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 20507

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 E 20507

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 826 n Luzerne ave ~~ST.~~ 17 WARD)

2-FULL NAME Christian J. Ebert.

(a) RESIDENCE No. 826 n Luzerne Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | ~~5 Single, Married, Widowed, or Divorced~~, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie A. Ebert

6 DATE OF BIRTH (month, day, and year) Dec. 2. 1903

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 23 | 3 | 19 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Office Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer) Bakery Sales + Del

(c) Name of employer Light St.

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER F. W. Ebert.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt.

12 MAIDEN NAME OF MOTHER Nellie M. Riley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant F. W. Ebert.

(Address) 826 N. Luzerne ave

Filed MAR 24 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 27

17

I HEREBY CERTIFY, That I attended deceased from March 11, 19 27, to March 21, 19 27,

that I last saw h[illegible] alive on March 21, 19 27

and that death occurred, on the date stated above, at 8 P m

The CAUSE OF DEATH* was as follows:

Intermittent Hemmoptysis

(duration) yrs. mos 2 ds

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward B Lennan M. D.

(Address) 718 N Patterson Park ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL March 24 27.

20 UNDERTAKER George J. Pratt

ADDRESS 1725 Hoffman ave

NOTE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE 20508

20508

## CERTIFICATE OF DEATH.

× 22

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. 4-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elsie M. Duvall

(a) RESIDENCE NO. Pasadena, Md. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 hrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr. 27, 1913

| 7 AGE | Years | Months | Days | * IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 13 | 10 | 23 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Magothy,

PARENTS

10 NAME OF FATHER Oliver S. Duvall

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Magothy

12 MAIDEN NAME OF MOTHER Laura V. Watts

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Glen Burnie

14 Informant Mrs. Laura V. Duvall (Mother)

(Address) Magothy, Md.

15 Filed MAR 24 1927 Per C. HAMPSON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 22 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry.)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Ascending Myelitis

(Etiology, Antecedent

Etiology. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Arnold Pinkett M. D.
(Coroner)

, 19 27 (Address) 3325 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Magothy Cemetery Date of Burial Mar 25 1927

20 UNDERTAKER John F Denny ADDRESS 715 Lexington St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20509

## CERTIFICATE OF DEATH.

E 20509

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2122 N. Calvert (St.) 12-50 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Etta May George

(a) RESIDENCE NO. Gary, Indiana (St.) (Ward)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William George

6 DATE OF BIRTH (month, day, and year): Oct. 28-1875

7 AGE: Years 51 Months 4 Days 20 If LESS than 1 day, ..... hrs or ..... min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pennsylvania

PARENTS

10 NAME OF FATHER: Josiah Hazard Hamilton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pennsylvania

12 MAIDEN NAME OF MOTHER: Sarah Ann Mitchell

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Pennsylvania

14 Informant: Clay J. George

(Address) Rt. 6 B Gary Indiana

Filed MAR 24 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 20 1927

17 I HEREBY CERTIFY, That I attended deceased from 3/7, 1927, to 3/20, 1927, that I last saw her alive on Mar. 20, 1927 and that death occurred, on the date stated above, at 10½ P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Liver

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Revorsoff, M. D.

3/20 1927 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: March 24 1927

20 UNDERTAKER: Horace H. Burgee — ADDRESS: 363 Fulton

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 20510 (upper left)

129 v

18-26

E 20510 REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1210 West Fayette St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Kent

(a) RESIDENCE NO. 1210 West Fayette St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward E. Kent

6 DATE OF BIRTH (month, day, and year) September 17, 1862

| 7 AGE | Years | Months | Days | IF LESS than 1 day ... hrs. or ... min.. |
|---|---|---|---|---|
| | 64 | 6 | 4 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,

(State or country) Maryland

PARENTS

10 NAME OF FATHER John George Engel

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Elizabeth Mineuch

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) United States

14 Informant Edward E. Kent

(Address) 1210 West Fayette Street

15 Filed MAR 24 1927

C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21, 1927

17 I HEREBY CERTIFY, That I attended deceased from March 5, 1927, to March 21, 1927,

that I last saw her alive on March 21, 1927,

and that death occurred, on the date stated above, at 5.10 p. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) John H Evans, M. D.

3-22-1927 (Address) 612 West 40th Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — Date of Burial Mar. 24 1927

20 UNDERTAKER Joseph D Cook — ADDRESS 1003 N Gilmor St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 20511

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20511

## CERTIFICATE OF DEATH

REGISTERED NO. 11-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 3308 Ridgewood Ave St. 15-W Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gladys K. Reed

(a) RESIDENCE NO. 3308 Ridgewood Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residenre in city or town where death ocrurred 22 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Raymond Reed

6 DATE OF BIRTH (month, day, and year): April 5, 1904

7 AGE: Years 22 Months 11 Days 18 IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in whirh employed (or employer):

(c) Name of employer

9 BIRTHPLACE (rity or town): md.

(State or country)

PARENTS

10 NAME OF FATHER: John Shockey.

11 BIRTHPLACE OF FATHER (City or town): md

(State or country)

12 MAIDEN NAME OF MOTHER: Lina Kellymon

13 BIRTHPLACE OF MOTHER (city or town): md.

(State or country)

14 Informant: Raymond Reed.

(Address) 3308 Ridgewood ave

15 Filed ....., 19.....

C. HAMILTON JOHNS, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 23, 19 27.

17 I HEREBY CERTIFY, That I attended deceased from 3-21, 19 27, to 3-23, 19 27

that I last saw her alive on 3-23, 19 27

and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 2 da.

CONTRIBUTORY (Secondary): Influenza Typhoid

(duration) yrs. mos 3 da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Smear

(Signed) C. Hamilton Johns M. D.

3/24 1927 (Address) 3701 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem.

Date of Burial: Mar. 26 1927

20 UNDERTAKER: Chenowethson.

ADDRESS 3615 Christ ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 20512

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20512

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Maryland General Hospital

REGISTERED NO. 57

CITY OF BALTIMORE: (No. 15-61 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Ciara T. Mc Gill (or MacGill)

(a) RESIDENCE NO. 2208 Jefferson Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 21, 1860

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 67 | 2 | 2 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland.
(State or country)

PARENTS

10 NAME OF FATHER John Sabin

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Eliza Howard

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Hooper Evans
(Address)

Filed MAR 24 1927 HAMPSON JONES, M. D., Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23 1927

17

I HEREBY CERTIFY, That I attended deceased from March 18, 1927, to April 23, 1927,

that I last saw h[illegible] alive on April 23, 1927,

and that death occurred, on the date stated above, at 12 [illegible] m.

The CAUSE OF DEATH* was as follows:

Acute Pancreatitis

Appendicitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? Yes Date of 3-18-27

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Hooper Evans

, 19 (Address) Hooper Evans

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL May 25 1927

20 UNDERTAKER Harry R. Annacott — ADDRESS 4202 Hodgewood Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20513

## CERTIFICATE OF DEATH.

118-601 E 20513

1-PLACE OF DEATH U. S. Marine Hospital No 1 12-51

CITY OF BALTIMORE: (No. Balto Md ST. WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alex W. Thompson

(a) RESIDENCE NO 2114 Maryland Ave. City ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N.B.—WRITE PLAINLY, WITH INDELIBLE INK. THIS IS A PERMANENT RECORD. Every item of information should be carefully furnished. AGE, CAUSE OF DEATH in plain terms (NO TECHNICAL) PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single. |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1881.

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 46 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer S/S W. F. Stead. Bltd.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Samuel J. Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ind.

12 MAIDEN NAME OF MOTHER C. Winchester

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Self
(Address)

15 Filed MAR 24 1927 . 19 C. HAMPSON JONES, M. D. Registrar

For

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23 1927.

17 I HEREBY CERTIFY, That I attended deceased from March 3, 1927, to March 23, 1927, that I last saw him alive on March 23, 1927, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Lobar.
Left.

(duration) — yrs. — mos. 14 ds.

CONTRIBUTORY (Secondary) Uncertain

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? Yes Date of 3/7/27.

Was there an autopsy? No

What test confirmed diagnosis? Physical findings & laboratory test

(Signed) E. L. Wilmoth, M. D.

19 (Address) U.S. Marine Hospital No. 1 Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Leesburg Va

DATE OF BURIAL 3/26/27

UNDERTAKER Geo. A. Tarby

ADDRESS Baltimore Md.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20514

CERTIFICATE OF DEATH

100-001

E 20514

REGISTERED NO.

1-PLACE OF DEATH Balto City Hospts.

City of BALTIMORE: (No. Balto Md. Street 25-7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Zella F. Landes

(a) RESIDENCE NO. 1415 Main St Monrel Park, Md. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Eugene P Landes

6 DATE OF BIRTH (month, day, and year): Aug 6 1887

7 AGE: Years 39 — Months 7 — Days 17 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 037

(b) General nature of industry, business, or establishment in which employed (or employer): Housework

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Ohio

PARENTS

10 NAME OF FATHER: J. L. Conrad

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Unknown

12 MAIDEN NAME OF MOTHER: Mary Wedch

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Ohio

14 Informant: Balto City Hospt

(Address): Balto Md

MAR 24 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19,: 3-22 27

17

I HEREBY CERTIFY, That I attended deceased from 3-10-, 1927 to 3-23-, 1927

that I last saw h[illegible] alive on 3-23-, 1927

and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows: Cardiac Exhaustion with Terminal Bronchopneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Toxic Exhaustive Psychosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? [illegible]

What test confirmed diagnosis? Balto City Hospitals

(Signed) Mary H Edwards M. D.

19 19 27 (Address) Balto, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Date of Burial Mar 26 19 27

20 UNDERTAKER: W. H. Cook ADDRESS 2[illegible] E Madison

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E. 20515

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 E 20515

## CERTIFICATE OF DEATH

1-PLACE OF DEATH Union Memorial Hosp REGISTERED NO. 25-72

City of BALTIMORE: (No. 33d & Calvert St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Russell Francis Williamson

(a) RESIDENCE NO. 1228 Seventh St Morrell Park St. Ward Baltimore

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): August 20, 1925

7 AGE: Years 1 Months 7 Days 4

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: baby

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER: John Williamson

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Louise Slade

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md.

14 Informant: Hospital Records

(Address)

15 Filed MAR 24 1927 19 C. HAMPSON JONES, M. D. Registrar

Per R.M.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: March 24, 1927

17 I HEREBY CERTIFY, That I attended deceased from March 17, 1927, to March 24, 1927,

that I last saw him alive on March 24, 1927,

and that death occurred, on the date stated above, at 6 15 A m.

The CAUSE OF DEATH* was as follows:

1 Bronchopneumonia

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? lab + clinical methods

(Signed) Hunter Smith, Jr., M. D.

19 (Address) Union Memorial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cambridge Md — Date of Burial 3/25 19

20 UNDERTAKER: Norman Cook — ADDRESS 902 Linden

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20516

## CERTIFICATE OF DEATH

90 E 20516

REGISTERED NO.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

City of BALTIMORE: (No. 505 S. Ewley St. 1-2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah E. Cunningham

(a) RESIDENCE NO. 505 S. Ewley St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alexander Cunningham

6 DATE OF BIRTH (month, day, and year) June 19, 1851

| 7 AGE | Years | Months | Days | IF LESS than 1 day ____ hrs. or ____ min.. |
|---|---|---|---|---|
| | 75 | 9 | 3 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Alex. Williamson

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Not Known

14 Informant Mrs Lee. Briscoe

(Address) 505 S. Ewley St

15 Filed MAR 24 1927, 19 C. HAMPSON JONES, M. D. Registrar

Per K M

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22 1927

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1927, to March 21, 1927, that I last saw h[illegible] alive on March 21, 1927, and that death occurred, on the date stated above, at 2 15 A. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia (Terminal)

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Cardio-Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P.M.

(Signed) John J. Kruger, M. D.

, 19 (Address) 2627 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Oak Lawn Cemetery | Mar. 25. 1927 |
| 20 UNDERTAKER Henry Sander & Sons Inc | ADDRESS 1710 Fleet St. |

Spec.—7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

129 E 20517

E 20517
1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 524 N Chester St. 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John. J. Bayliss

(a) RESIDENCE NO. 524 N Chester St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Amelia R Bayliss

6 DATE OF BIRTH (month, day, and year) 2-12-1872

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min.. |
|---|---|---|---|---|
| | 65 | 1 | 20 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk. odf

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Bernard Bayliss

11 BIRTHPLACE OF FATHER (City or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara B Kochman

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Amelia R Bayliss
(Address) 524 N Chester St

15 Filed MAR 24 1927 19 C. HAMPSON JONES Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-22nd 1927

17 I HEREBY CERTIFY, That I attended deceased from March 19th 1927 to March 22nd 1927.

that I last saw h. wife alive on March 22nd 1927.

and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

?

(duration) yrs. mos. ds.

CONTRIBUTORY ✓
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted ✓

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical & lab

(Signed) Isidor S. Levy M. D.

Mar. 1927 (Address) 2036 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem. — Date of Burial 3-25th 1927

20 UNDERTAKER Earl B Harle — ADDRESS 1156 N 2nd St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 20518 HEALTH DEPARTMENT—CITY OF BALTIMORE E 20518

CERTIFICATE OF DEATH.

5-22 161-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1316 W. Fulton Ave. ST.) (WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Frances Baker,

(a) RESIDENCE. No. 1316 W. Fulton Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar 21 1927.

7 AGE — Years — Months — Days 2 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Roland Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Annapolis Md.

12 MAIDEN NAME OF MOTHER Helen F. Santmyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

11 Informant Helen F. Baker
(Address) 1316 W. Fulton Ave.

13 Filed MAR 24 1927 C. HAMPSON JONES, M. D. Registrar

Per —

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23 1927

17 I HEREBY CERTIFY, That I attended deceased from March 21, 1927, to March 23, 1927, that I last saw her alive on March 23, 1927, and that death occurred, on the date stated above, at 11 45 P. m.

The CAUSE OF DEATH* was as follows:

Premature birth

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) — none —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? Skin & Physical.

(Signed) John D. Clinton, M. D.

3/24, 1927 (Address) 507 W. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem Co. DATE OF BURIAL: 3-24 1927

20 UNDERTAKER: Mrs Chas A G Rohde ADDRESS: 1100 N Arlington Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec. 12-9-25—A Co.—200 Blks.

See Letter in file from Dr W E Gatteus 4-21-27

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20519

E 20519

CERTIFICATE OF DEATH.

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. 17-25 Ward)

2-FULL NAME Philip ~~Filippo~~ Sanpsliefo

(a) RESIDENCE NO. 406 Pearl st. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? 26 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1896

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 31 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fruit dealer

(b) General nature of industry, business, or establishment in which employed (or employer) Fr Service Man

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Italy

PARENTS

10 NAME OF FATHER Michael ~~Sanpsliefo~~

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Italy

12 MAIDEN NAME OF MOTHER Josephine Flippo

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Italy

14 Informant Hospital Records

(Address)

MAR 24 1927

15 Filed HAMPSON JONES, M. D. Registrar

Per R.H.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23, 1927 19

17

I HEREBY CERTIFY, That I attended deceased from Feb. 18, 19 27, to March 23, 19 27,

that I last saw him alive on March 23, 19 27,

and that death occurred, on the date stated above, at 5.15 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W E Gatteus, M. D.

3-22-27, 19 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery Date of Burial 3/26 1927

20 UNDERTAKER George J. Ruth ADDRESS 1735 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

# E 20520 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

86-002 E 20520

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital St.) (8-17 WARD)

2-FULL NAME Katherine Kestler

(a) RESIDENCE NO. 1620 Hoffman ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | white | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Feb 27. 1915

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 12 | — | 28 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School

(b) General nature of industry, business, or establishment in which employed (or employer): Public School

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER Wm Kestler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER Catherine Sullivan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Katherine Kestler

(Address) 1620 Hoffman St

15 Filed MAR 24 1927, 19 ... Registrar

E. HAMILTON JONES, M. D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-23 1927

17

I HEREBY CERTIFY, That I attended deceased from 3-8, 1927, to 3-23, 1927,

that I last saw h[illegible] alive on 3-23, 1927,

and that death occurred, on the date stated above, at 10 10 a. m.

The CAUSE OF DEATH* was as follows:

Meningitis streptococcus following mastoiditis

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3-8-27

Was there an autopsy? No

What test confirmed diagnosis? Physical & Lab. exam.

(Signed) W L McBride M. D.

, 19 (Address) 1621 St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery

DATE OF BURIAL: 3/26 1927

20 UNDERTAKER: George F. Ruth

ADDRESS: 1735 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Blks.

E 20521

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

12-54-001

REGISTERED NO. E 20521

1-PLACE OF DEATH

City of BALTIMORE: (No. Union Memorial Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Rosenbloom

(a) RESIDENCE NO. 2424 Eutaw Pl St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? 40 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White Russian

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~: Mrs Jacob Rosenbloom

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 65 Months ? Days ? IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Manufacturer of Shirts

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Russia

PARENTS

10 NAME OF FATHER Elisa Rosenbloom

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Russia

12 MAIDEN NAME OF MOTHER Anonia Glass

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Russia

14 Informant: Mrs Jacob Rosenbloom

(Address): 2424 Eutaw Pl. Balto

15 Filed MAR 24 1927 Per RJC

C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

March 24 1927

17 I HEREBY CERTIFY, That I attended deceased from Mch 15, 1927, to Mch 24, 1927.

that I last saw h/ alive on Mch 24, 1927.

and that death occurred, on the date stated above, at 11-10 A m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia following. 2nd attack of Grippe one 3 mo ago one 3 wks ago (duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Home 2424 Eutaw Pl

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Louis Olch Taylor, M. D.

. 19 (Address) Union Mem Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale — Date of Burial 3/25 1927

20 UNDERTAKER: Jack Levin — ADDRESS 1139 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20522

## CERTIFICATE OF DEATH.

101-001

E 20522
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1050 N. Durham ST. 7-13 WARD)

2-FULL NAME Henry McKinney

(a) RESIDENCE NO. 1050 N Durham ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | C | Married |

5a If married, widowed, or divorced
~~WIFE of~~ HUSBAND of Susie McKinney

6 DATE OF BIRTH (month, day, and year) Oct 13, 1890

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 36 | — 5 | — 9 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron Worker (?)

(b) General nature of industry, business, or establishment in which employed (or employer) Foundry

(c) Name of employer Central Foundry Co

9 BIRTHPLACE (city or town) (State or country) Buckland Ga

PARENTS

10 NAME OF FATHER Sam. McKinney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ga.

14 Informant Susie McKinney wife
(Address) 1050 N Durham St

15 Filed MAR 24 1927, 19 C. HAMILTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1926 to March 22 1927.

that I last saw h im live on March 21, 1927

and that death occurred, on the date stated above, at 5 00 A.M.

The CAUSE OF DEATH* was as follows:

Empyema.
(Complication of the Pneumonia)
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia.
(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R T Young, M. D.

3/24 1927 (Address) 1429 E Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Waycross Ga.

DATE OF BURIAL March 24 27

20 UNDERTAKER Mrs. A. A. Elliott

ADDRESS 1423 Eastlake

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20523

## CERTIFICATE OF DEATH.

46 E 20523

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 707 Harlem Ave ST. 17-26 WARD)

2-FULL NAME Lola M. Peace

(a) RESIDENCE NO. 707 Harlem Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 ~~Single~~, Married, Widowed, ~~or Divorced, (write the word)~~: Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Peace.

6 DATE OF BIRTH (month, day, and year): [illegible] 1886

7 AGE: Years 41; Months; Days; If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Keeper

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: at home

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Loudlen Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Mary Lovell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant (Address): H. Husband Henry Peace 707 Harlem Ave

Filed MAR 24 1927 M. HAMPTON JONES, M. D. Registrar

By RM

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 21 1927

17

I HEREBY CERTIFY, That I attended deceased from March 16, 1927, to March 21, 1927, that I last saw her alive on March 21, 1927, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Gangrene - Carcinoma of Uterus

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Carcinoma of Uterus Complication Vessel

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Dr Gill Kennard M. D.

3-27-1927 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Atlanta Ga. VW — DATE OF BURIAL: Mar 25 1927

20 UNDERTAKER: Mrs. R. G. Elliott — ADDRESS: 112 Auchland

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20524

## CERTIFICATE OF DEATH

9 E 20524

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1136 N. Monroe St. 16-22 Ward)

2-FULL NAME Margaret Farrell

(a) RESIDENCE NO. 1136 N. Monroe St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widowed |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Thomas J. Farrell

6 DATE OF BIRTH (month, day, and year) May 17, 1878

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|---|
| | 48 | 10 | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs Hooker

(Address) 1136 N Monroe St

15 Filed MAR 24 1927

C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

March 23 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1926, to March 23, 1927,

that I last saw h[illegible] alive on March 23, 1927,

and that death occurred, on the date stated above, at 12 45 m.

The CAUSE OF DEATH* was as follows:

Valvular disease of Heart

(Chronic)

(duration) 7 yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs.

(Signed) Sidney K. Shultz M. D.

3/23. 1927 (Address) 475 E Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — Date of Burial March 26 1927

20 UNDERTAKER Mr-Mrs A S Funk — ADDRESS 2512 Hillen Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20525

## CERTIFICATE OF DEATH

90 E 20525

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 511 N Washington St., 79 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Philip H Croney Sr

(a) RESIDENCE NO. 511 N Washington St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 90 yrs. 10 mos. 23 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret B Croney.

6 DATE OF BIRTH (month, day, and year): Apr 30 1836

7 AGE: Years 90 Months 10 Days 23 IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired 017

(b) General nature of industry, business, or establishment in which employed (or employer): Cigar Maker

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: John W. Croney

11 BIRTHPLACE OF FATHER (City or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Dont Know

14 Informant: Dr David Finnegan (Address) 511 N Washington St

15 Filed MAR 24 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: 3/23/1927

17 I HEREBY CERTIFY, That I attended deceased from Mar. 12 1927 to Mar. 23 1927 that I last saw him alive on Mar. 23 1927 and that death occurred, on the date stated above, at 11.15 P.m.

The CAUSE OF DEATH* was as follows:

Aortic Obstruction

not diagnosed

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? V

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) Benj. D. Hampson M. D.

3/24/1927 (Address) 1216 N. Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem. Date of Burial: Mar 26 1927

20 UNDERTAKER: John Merrick ADDRESS: 9 E Orleans

Spec.—1-12-23—M&T—500 Bks.

E 20526

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20526

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 601 South Paca ST. 22-30 WARD)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME DR. JOSEPH ABROMAITIS

(a) RESIDENCE No. 601 South Paca ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | MARRIED |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) No. 1866

7 AGE 60 Years — Months — Days (61) If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dr. 054

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer No.

9 BIRTHPLACE (city or town) (State or country) Lithvania

PARENTS

10 NAME OF FATHER Joseph Abromaitis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithvania

12 MAIDEN NAME OF MOTHER M. Kubilute

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithvania

14 Informant V. Abromaitis

(Address) 601 S. Paca Street

15 Filed MAR 24 1927, 19 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1926, to March 23, 1927, that I last saw him alive on March 21, 1927 and that death occurred, on the date stated above, at 3.15 P. m.

The CAUSE OF DEATH* was as follows:

Myocanditis

(duration) 1 yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. 2. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Findings

(Signed) John A. Buchness, M. D.

, 19 (Address) 375 Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus — DATE OF BURIAL Feb. 26, 19 27

20 UNDERTAKER John Greblianckas — ADDRESS 823 S. Paca St

I. D.

INFORMATION, WITH CERTIFICATE FOR BURIAL PERMIT, REQUIRED BY ORDINANCE. Each question should be answered, with the information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

20527

## CERTIFICATE OF DEATH

X 101-201 ✓

E 20527

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. Provident Hospital St., 11 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Knight.

(a) RESIDENCE NO. 8 Parrs Pl. St. Panacea, Sp. Pl. Md. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie Knight

6 DATE OF BIRTH (month, day, and year): Not Known

7 AGE: Years: Abt 42 — Months: — — Days: — — IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer): Bethlehem Steel Co

(c) Name of employer

9 BIRTHPLACE (city or town): Littleton

(State or country): North Carolina

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (City or town): Not Known

(State or country)

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town): Not Known

(State or country)

14 Informant: Henry Edwards

(Address): Littleton N. C.

15 Filed MAR 24 1927 — 19 — C. HAMPSON JONES, M. D. Registrar

Per — ORH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/23/27 — 19

17 I HEREBY CERTIFY, That I attended deceased from March 16th, to March 23rd, 1927.

that I last saw him alive on March 23rd, 1927.

and that death occurred, on the date stated above, at 11:45 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Parrs Pl. Md

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J. F. Thomas, M. D.

. 19 (Address) 1012 S. Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Littleton N.C. Via Bay Line — Date of Burial: Mar 24 1927

20 UNDERTAKER: John F. Dennis — ADDRESS: 715 Light

Cor.—12-9-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20528

E 20528

## CERTIFICATE OF DEATH.

23-24 25-001

REGISTERED NO. _____

1-PLACE OF DEATH

City of BALTIMORE: (No. 1626 Light St. St. _____ Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eva Edith White.

(a) RESIDENCE NO. 1626 Light St. St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female.

4 Color or Race: White.

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ---

6 DATE OF BIRTH (month, day, and year): December 28, 1926

7 AGE

| Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|
| 0 | 3 | 0 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore, Md.

(State or country)

PARENTS

10 NAME OF FATHER: Charles C. White.

11 BIRTHPLACE OF FATHER (city or town): Baltimore, Md.

(State or country)

12 MAIDEN NAME OF MOTHER: Annie E. Steward.

13 BIRTHPLACE OF MOTHER (city or town): Baltimore, Md.

(State or country)

14 Informant: Annie E. White. (mother)

(Address) 1626 Light St.

15 Filed C. HAMPSON JONES, M. D. 19 Registrar

MAR 24 1927

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 28, 1927. 19__

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia.

Chicken pox.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....

(duration) ....yrs. ....mos. ....ds.

(Signed) Otto Leonhardt M. D.

(Coroner)

3/24 19 27 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery

Date of Burial: 3/25 1927

20 UNDERTAKER: William Cook

ADDRESS: 502 E. Balt.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20529

E 20529

## CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2704 Parkwood Avenue, 13-59 WARD)

2-FULL NAME Octabia Geise

(a) RESIDENCE No. 2704 Parkwood ave ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | white | Widow |

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Geise

6 DATE OF BIRTH (month, day, and year) aug 20 1835

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs or ... min. |
|---|---|---|---|---|
| | 91 | 7 | 3 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) York Co. Penna

PARENTS

10 NAME OF FATHER Elias Folkmer

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Louisa Fortenroth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Quincy A. Geise

(Address) 2704 Parkwood ave

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

By .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 4 1927, to Mch 23 1927, that I last saw h alive on Mch 23 1927, and that death occurred, on the date stated above, at 11.P. m.

The CAUSE OF DEATH* was as follows: Chronic Valvular Myocarditis

(duration) 3 yrs mos ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Nathaniel Gorsuch M. D.

, 19 (Address) 1405 Guilford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lutheran Ground Seven Valley York Co. Pa — DATE OF BURIAL March 25 1927

20 UNDERTAKER Chas. T. Black — ADDRESS 742 W. North ave

MARION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS would state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

R24

Spec.—6-9-19—H. P. Co.—1000 Blks.

E 20530

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20530

## CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1523 E. Preston ST. 8813 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arabella F. Miles

(a) RESIDENCE. NO. 1523 E. Preston ST. 8 — WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 00 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of John W. Miles

6 DATE OF BIRTH (month, day, and year) Octob. 3 - 1853

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 73 | 5 | 20 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Kingsville

(State or country) Baltimore Co. Md.

PARENTS

10 NAME OF FATHER Wm. Smith

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Jane Howell

13 BIRTHPLACE OF MOTHER (city or town) unknown

(State or country)

11 Informant Mrs Jane Irene Sparks

(Address) 1-28 E. Preston St

15 Filed MAR 24 1927 19 C. HAMPSON JONES, M. D. Registrar

Per ARH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 23 - 1927

17

I HEREBY CERTIFY, That I attended deceased from Dec. 24 - 1926, to Mar. 23 - 1927.

that I last saw her alive on March 23 - 1927.

and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) — yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edwin B. Fenby, M. D.

3/24/1927 Address 1223 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: March 26 1927

20 UNDERTAKER: Chas. G. Black — ADDRESS: 942 N. North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. -7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20531

# CERTIFICATE OF DEATH

90 E 20531

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 3710 Chestnut Ave. St. 13-57 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Sproul

(a) RESIDENCE NO. 3710 Chestnut Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Catherine E. Sproul

6 DATE OF BIRTH (month, day, and year): Feb 22, 1855

7 AGE: Years 72 Months 1 Days 1 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Dr

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Md.

(State or country)

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (City or town): Unknown

(State or country)

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): Unknown

(State or country)

14 Informant: Catherine E. Sproul

(Address) 3710 Chestnut Ave

15 Filed MAR 24 1927 C. HAMPSON JONES, M. D. Registrar

Per

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 23, 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 1, 1927 to Mar 23, 1927

that I last saw him alive on Mar 22, 1927

and that death occurred, on the date stated above, at 5 A. M.

The CAUSE OF DEATH* was as follows:

Ch. Valvular Heart Disease

(duration) 5 yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin.

(Signed) [signature], M. D.

3/23/1927 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oaklawn Cem. Date of Burial: Mar 25, 1927

20 UNDERTAKER: Thenowethdon. ADDRESS 3615 Chestnut Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20532 E 20532

## CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1911 W. Mulberry ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME ~~Carl~~ Caroline D. Manter

(Residence in Baltimore: No. 1911 W. Mulberry St St. 63 yrs. mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH. March (Month) 16 (Day), 1864 (Year)

7-AGE. 63 yrs. mos. 7 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. At home
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. John Richtenhofer

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER. K Schmidt

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John M. Snyder

(Address) #1116 Barclay St.

15-

Filed APR 24 1927, 191

C. HAMPSON JONES, M. D.

Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. March (Month) 23 (Day) 1927 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 21 1927, to March 23 1927, that I saw her alive on March 23 1927, and that death occurred, on the date stated above, at 2:40 p. m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) yrs. mos. 1 ds.

(Signed) B. Krauss M. D.

, 191... (Address) 2306 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Dallis Cemetery

DATE OF BURIAL, March 25, 1927

20-UNDERTAKER, Robert Brookes

ADDRESS Calhoun & Fulton

Spec.–7-17-26—A Co.—200 Bks.

E 20533

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20533

## CERTIFICATE OF DEATH

1-PLACE OF DEATH Union Memorial Hospital REGISTERED NO. 12-44

City of BALTIMORE: (No. 33[2]-a Calvert St St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Berta a Virginia Thompson

(a) RESIDENCE NO. Glencoe Md St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) September 15, 1925

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 1 | 6 | 9 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland

(State or country)

PARENTS

10 NAME OF FATHER Elmer M Thompson

11 BIRTHPLACE OF FATHER (City or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Anna I Cramer

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Hospital Records

(Address)

15 MAR 24 1927 C. HAMPSON JONES, M. D.

Per RKS Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

March 24, 1927

17 I HEREBY CERTIFY, That I attended deceased from March 9, 1927, to March 24, 1927, that I last saw her alive on March 24, 1927, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Meningitis tuberculosa

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) otitis media, bronchopneumonia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted

If not at place of death? not known

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical & laboratory findings

(Signed) Randall Souter, Jr., M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel. Baltimore Co. Md. Date of Burial Mar 27 1927

20 UNDERTAKER E LeRoy Stiffler ADDRESS 1252 Woodbine

R. R—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20534

E 20534

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital St., 9-17 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Catherine S. Matthew

(a) RESIDENCE NO. Stemmer's Run, Md St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | white | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Matthew

6 DATE OF BIRTH (month, day, and year) Oct 4/1897

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 29 | 5 | 18 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Adam Stein

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Wahl

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant John Matthew

(Address) Stemmer's Run, Md

15 Filed 3/24 1927 C. HAMPSON JONES, M. D. Registrar

Per

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 Mar 22/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Septicemia-Puerpal (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Abortion-Accidental (duration) yrs. mos. ds.

(Signed) [signature] M. D.

(Coroner)

3/24/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakland Cem Date of Burial Mar. 25 1927

20 UNDERTAKER J. G. Connolly ADDRESS Ewer Md.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CA... OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIO... very important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20535

E 20535

## CERTIFICATE OF DEATH

90

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 615 S Bethel St 7-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stanislaus Kowalewski

(a) RESIDENCE NO. 615 S Bethel St St. Ward
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S. if of foreign birth? 38 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Antonina Kowalewski

6 DATE OF BIRTH (month, day, and year) April 23 1875

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 51 | 11 | 1 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 040

(b) General nature of industry, business, or establishment in which employed (or employer) Labor

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Poland

PARENTS

10 NAME OF FATHER John Kowalewski

11 BIRTHPLACE OF FATHER (City or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER Julianna Janowska

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14 Informant Antonina Kowalowski
(Address) 615 S Bethel St

15 Filed MAR 24 1927 Per C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24 1927

17 I HEREBY CERTIFY, That I attended deceased from March 9. 1927. to March 20. 1927
that I last saw him alive on March 20. 1927.
and that death occurred, on the date stated above, at 3:15 A. m.

The CAUSE OF DEATH* was as follows:

Valvular heart disease

1 (duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) acute dilatation of heart

(duration) yrs. mos. 3 ds.

18 Where was disease contracted
If not at place of death? unknown
Did an operation precede death? no Date of
Was there an autopsy? no Pathological examination
What test confirmed diagnosis?
(Signed) Samuel Silverstein M. D.
. 19 (Address) 22 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial
Holy Rosary March 28 1927

20 UNDERTAKER — ADDRESS
John M Wilson 1803 Hanover

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

E 20536

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20536

## CERTIFICATE OF DEATH.

REGISTERED NO. 13259 44

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 1510 Clifton ave ST. (or) 23 WARD)

2-FULL NAME George B Blair

(a) RESIDENCE NO. 1510 Clifton ave ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| M | W. | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eliza A Blair

6 DATE OF BIRTH (month, day, and year) Sept 15, 1856

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 70 | 6 | 7 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Father 58
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Geo. W Blair

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Emma Popp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Alberta Blair
(Address) 1510 Clifton Ave

15 Received MAR 24 1927 C. HAMPSON JONES, M. D. Registrar
Per RKH

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/22 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) John H Morrison, M. D.
(Coroner.)

3/24, 1927 (Address) 1532 Rd Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park DATE OF BURIAL Mar 25 1927

20 UNDERTAKER W. Cook ADDRESS 502 E North Ave

TION is very important. See instructions on back of certificate. Exact statement of OC

Spec.—7-17-26—A Co.—200 Bks.

Dr Steuken 3949 Fremont Ave

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20537

E 20537

## CERTIFICATE OF DEATH

REGISTERED NO. 90

1-PLACE OF DEATH

City of BALTIMORE: (No. 401 Woodleigh Rd St. 27-41 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Douglas Weir

(a) RESIDENCE NO. 401 Woodleigh Rd St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W. | Married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary M Weir

6 DATE OF BIRTH (month, day, and year) June 29, 1859

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min.. |
|---|---|---|---|---|
| | 67 | 8 | 25 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman, Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 066

9 BIRTHPLACE (city or town) Balto

(State or country) Md

PARENTS

10 NAME OF FATHER Robert Weir

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Eliza Johnson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Mrs Elliot Jones

(Address) 401 Woodleigh Rd

15 Filed MAR 24 1927 C. HAMPSON JONES, M. D. Registrar

Per DKH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 24 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 27 1926 to Mch. 24 1927.

that I last saw him alive on Mch 24 1927.

and that death occurred, on the date stated above, at 9:30 a. m.

The CAUSE OF DEATH* was as follows:

Angina pectoris

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Aortic insufficiency

(duration) 1 yrs. 3 mos. ds.

18 Where was disease contracted — to my knowledge

if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. D Steuken M. D.

3/24/1927 (Address) 3949 Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fremont — Date of Burial Mch 26 1927

20 UNDERTAKER J. H. Cook — ADDRESS Woodlawn

E—WRITE PLAINLY, WITH UNFADING INK—This is a PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 20538

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20538

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST., 9-47 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Ida A. Gerland

(a) RESIDENCE NO. 3941 Lawndes Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4/5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | white | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Gerland

6 DATE OF BIRTH (month, day, and year) Sept 19 1868

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 58 | 6 | 5 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER not given

11 BIRTHPLACE OF FATHER (city or town) (State or country) " "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant Louis Gerland

(Address) 3941 Lawdes Ave

Filed MAR 24 1927 C. HAMPSON JONES, M. D. Registrar

Pat

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-24 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan 14, 1927, to Mar 24, 1927, that I last saw h alive on Mar 24, 1927, and that death occurred, on the date stated above, at 145 a. m.

The CAUSE OF DEATH* was as follows:

Pernicious anaemia (secondary)

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Carcinoma of Liver

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Wound

(Signed) Seymour Pollock M. D.

3-24, 1927 (Address) 2206 Mon St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenhill Cem. DATE OF BURIAL Mar 28 1927

20 UNDERTAKER W. M. Cook ADDRESS 512 E Fort Ave

INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20539

## CERTIFICATE OF DEATH.

1927 E 20539

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hospital Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lola Mildred Rupp

(a) RESIDENCE NO. 2741 E Chase St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) unknown 1906

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 21 | — | — | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Worked in Printing Dept
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer Md Casualty Co

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Julius Rupp

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto

12 MAIDEN NAME OF MOTHER Lola N. Weickittle

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto

14 Informant August H. Hilderbrand
(Address) Glenmore & Ridgeway Ave

15 Filed 3-24-1927 C. HAMPSON JONES, M.D. Registrar
By AKB

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23rd 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Abortion — do not know who performed it
Entered Hospital Mch 19/27
died Mch 23/27.

CONTRIBUTORY (Secondary) Septicemia (duration) yrs. mos. ds.

(Signed) Thos. B. Horton M. D.
(Coroner)

Mch 24, 1927 (Address) Curtis Bay, Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos. 4 ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence 2741 E. Chase St.

PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. Date of Burial Mar 26 1927

20 UNDERTAKER William Cook ADDRESS 502 E Northern

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20540

## CERTIFICATE OF DEATH.

90 E 20540

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (Name of Hospital) JOHNS HOPKINS HOSP. St. 17-24 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Alonzo Lewis

(a) RESIDENCE NO. 931 Argyle Ave - Balto Md Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Col- | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lela

6 DATE OF BIRTH (month, day, and year) Jan 1873

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 54 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md -

PARENTS

10 NAME OF FATHER Bebly Lewis

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md -

12 MAIDEN NAME OF MOTHER Lydia Atkins

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Records -

(Address) JOHNS HOPKINS HOSPITAL

15 Filed MAR 25 1927 E. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927

Mar 22, 1927

17

I HEREBY CERTIFY, That I attended deceased from Mar 15, 1927, to Mar 22, 1927, that I last saw him alive on Mar 22, 1927, and that death occurred, on the date stated above, at 5:10 P m.

The CAUSE OF DEATH* was as follows: Heart Block, Asystystole

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Gradual onset

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) E Coutes Suarez, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Date of Burial 3-25 1927

20 UNDERTAKER John N. Toadvine ADDRESS 1627 Eutaw Pl

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20541 ✓ 45 E 20541

## CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1829 N. Aisquith St., 9-18 WARD)

2-FULL NAME Annie T. Milligan

(a) RESIDENCE NO. 1829 N. Aisquith ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles I. Milligan

6 DATE OF BIRTH (month, day, and year) Jan. 18, 1875

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 52 | 2 | 4 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Baltimore City

9 BIRTHPLACE (city or town) Harford Co.
(State or country) Maryland

PARENTS

10 NAME OF FATHER Milton Krause

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Agnes Gallagher

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Miss Mary A. Milligan
(Address) 1829 N. Aisquith Street

15 Filed MAR 25 1927. C. HAMPSON JONES, M. D. Registrar RR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 23 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 12, 1926, to Mar 23, 1927, that I last saw h alive on Mar 23, 1927, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of mesentery

(duration) — yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Xray

(Signed) A C Monninger M. D.

3-24. 1927 (Address) 323 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Peter's Cemetery

DATE OF BURIAL 3/ 26 1927

20 UNDERTAKER Henry U. Mears & Sons

ADDRESS W. Calvert

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20542

## CERTIFICATE OF DEATH.

131 E 20542

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1709 Orleans ST. 64 WARD)

2-FULL NAME Alice Jackson Kead

(a) RESIDENCE NO. 1709 Orleans st ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | C | Married |

5a If married, widowed, or divorced (or) WIFE of Howard Kead

6 DATE OF BIRTH (month, day, and year) ~~January~~ January 9 1884

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or ..... min. |
|---|---|---|---|---|
| 43 | 42 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Howard Kead (Husband)
(Address) 1709 Orleans st

15 Filed ..... 19 ..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1927. to March 24 1927.

that I last saw h alive on March 23 1927.

and that death occurred, on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Pyletis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Severe Bronchitis and Pleurisy (duration) 5 weeks yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R J Yost, M. D.

3/24 1927 (Address) 1424 E Monument st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Furnish Branch No 2

DATE OF BURIAL mar 27 1927

20 UNDERTAKER Edward Bryan

ADDRESS 1631 Orleans st

MAR 25 1927

C. HARRISON JONES, M. D.

Health officers to carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 20543

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 20543

Registered No. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. 433 Rosedale Terrace St. 70-70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Eliza a. Frey

(a) Residence No. 433 Rosedale Terrace St., ..... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

### PERSONAL AND STATISTICAL PARTICULARS.

| 3-SEX. | 4-COLOR OR RACE. | 5-Single, Married, Widowed, or Divorced, (Write the word.) |
|---|---|---|
| female | white | widowed |

5a-If ~~married~~, widowed, ~~or divorced~~ HUSBAND ~~of~~ (or) WIFE of Gottlieb Frey

6-DATE OF BIRTH (month, day and year) May 2, 1850

7-AGE. 76 yrs. 10 mos. 21 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ..... domestic

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country). Calvert Co. Maryland

PARENTS.

10-NAME OF FATHER. James Pardoe

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Anne Boyd

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

14- (Informant) Mrs. A. C. Taylor

(Address) 433 Rosedale Ter.

15- Filed MAR 25 1927 192 C. HAMPSON JONES, M. D. Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 23, 1927

17- I HEREBY CERTIFY, That I attended deceased from Jan. 14, 1927 to March 23 1927

that I last saw her alive on March 23 1927

and that death occurred, on the date stated above, at 6.05 p. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis — myocardial insufficiency

about 10 —
(Duration) yrs. mos. ds

CONTRIBUTORY (Secondary) cardiac dilatation

(Duration) yrs. mos. 1 ds

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? usual tests —

(Signed) George A Kinyon M. D.

, 19 (Address) 3030 Edmondson Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

| 19-PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL. |
|---|---|
| Mt Olivet Cem | Mar 26, 1927 |
| **20-UNDERTAKER.** | **ADDRESS** |
| J. Fenton Sons | Fulton Ave |

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 20544 — REGISTERED NO. E 20544

74001

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hosp St. 15-21 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Davis Cohen

(a) RESIDENCE NO. 1925 N Fulton Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? 38 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | white | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Cohen

6 DATE OF BIRTH (month, day, and year) 1865

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 59 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 045

(b) General nature of industry, business, or establishment in which employed (or employer) Grocery Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) Russia

(State or country)

PARENTS

10 NAME OF FATHER Nathan Cohen

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Antown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Sarah Cohen

(Address) 1925 N. Fulton Ave

C. HAMPSON JONES, M. D.

15 Filed APR 25 1927 19 Per RR Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) no other history

(duration) yrs. mos. ds.

(Signed) J. T. Kennedy, M. D.

(Coroner)

March 24, 1927 (Address) 2 E 82 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Nestem Lem Date of Burial 3/28 1927

20 UNDERTAKER Jack Lewis ADDRESS 1439 E Baltimore St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

20545

## CERTIFICATE OF DEATH.

E 20545

1-PLACE OF DEATH Found floating at Standard Guano Wharf. REGISTERED NO.

City of BALTIMORE: (No. Curtis Bay. St. 4-25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wesley Baker.(C)

(a) RESIDENCE NO. 224 N.Pine St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married.

6a If married, XXXXXXXXXXXX HUSBAND of XXXXXXXX Eliza Baker.(C)

6 DATE OF BIRTH (month, day, and year): Do not know.

7 AGE: Years 85; Months ---; Days ---; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country) Virginia.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Do not know.

14 Informant Eliza Baker.(C) wife.

(Address) 1038 Druid Hill Ave.

15 Filed MAR 23 1927 By C. HAMPSON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Drowned Nov. 29, 1926. found March 19, 1927.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Drowning. Fell from a wharf. Accidental Death.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Kinnard (Coroner) M. D.

3/24 19 27 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Standard Guano Wharf. Curtis Bay.

Former or usual residence November 29, 1926.

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. Date of Burial 3/25 1927

20 UNDERTAKER Samuel Kussley ADDRESS 5[illegible]

Don should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 20546

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

91-002

E 20546

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 215 Mosher St. ST.) 14-20 (WARD)

2-FULL NAME Elizabeth Pelgleman Hollyday

(a) RESIDENCE NO. 215 Mosher St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | white | widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Richard Hollydays

6 DATE OF BIRTH (month, day, and year) Aug. 30, 1849

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 77 | 6 | 25 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John C. Earle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Clara Eliz. Goldsborough

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Margaret C. Bordley

(Address) 810 Cathedral St.

15 Filed APR 26 1927 19 C. HAMPSON JONES, M. D., Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 1927

17

I HEREBY CERTIFY, That I attended deceased from October 6 1925 to March 24 1927

that I last saw h Dr alive on March 24 1927

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Arterio sclerosis (Bulbar palsy)

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Charles H. Thurstgan, M. D.

19 (Address) 1417 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Easton, Md.

DATE OF BURIAL March 27 1927

20 UNDERTAKER John O. Mitchell

ADDRESS 1900 Eutaw Place

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26 –A Co.—200 Bks.

Egeberg.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20547

# CERTIFICATE OF DEATH

REGISTERED NO. E 20547

1-PLACE OF DEATH University Hospital

City of BALTIMORE: (No. 4 30 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Egeberg

(a) RESIDENCE NO. Lindsdale St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 20 da. How long in U. S. if of foreign birth? yrs. mos. da.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Martha Egeberg

6 DATE OF BIRTH (month, day, and year): Sept 4. 1892

7 AGE: Years 34 Months 6 Days 20 IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Fireman

(b) General nature of industry, business, or establishment in which employed (or employer): 080

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Albert Egeberg

11 BIRTHPLACE OF FATHER (City or town) (State or country): Norway

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant (Address): Hospital Records

15 Filed MAR 25 1927 19 C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/24 1927

17 I HEREBY CERTIFY, That I attended deceased from 3/3, 1927, to 3/24, 1927, that I last saw h... alive on 3/24, 1927, and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:

Lupus erythematosus (Chronic)

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Acute Edema of Lungs

(duration) yrs. mos. 25 da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 3/3/27

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Findings

(Signed) P. M. Hirsh, M. D.

3/24 1927 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Swartz Cemetery — Date of Burial: 3/25. 1927

20 UNDERTAKER: Sol Thurson & Bro — ADDRESS 1127 E Balto St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26–A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20548

## CERTIFICATE OF DEATH 126 × E 20548

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. University Hospital St. 4-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maurice Alexander

(a) RESIDENCE NO. Fort Howard St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 23 ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE: Years 20 Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Soldier

(b) General nature of industry, business, or establishment in which employed (or employer) U.S.

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town) Unknown

(State or country)

12 MAIDEN NAME OF MOTHER Bertha Rebel

13 BIRTHPLACE OF MOTHER (city or town) Unknown

(State or country)

14 Informant Hospital Record

(Address)

15 Filed APR 25 1927 By C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/24 1927

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1927, to March 24, 1927, that I last saw him alive on March 24, 1927, and that death occurred, on the date stated above, at 3.55 A m.

The CAUSE OF DEATH* was as follows:

Pneumococcic + Staphylococcus Generalized Peritonitis.

(duration) yrs. about 30 mos. ds.

CONTRIBUTORY Bilateral bronchopneumonia

(Secondary) Pneumococcic + Staphylococcus empyema on right

(duration) yrs. mos. 5 ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? Yes Date of 3/1/27 and 3/21/27

Was there an autopsy? Yes

What test confirmed diagnosis? Laboratory + Autopsy

(Signed) T. T. Lusby, M. D.

3/24 1927 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL 428 Carlton ave Hagerstown Md

Date of Burial 3/25 1927

20 UNDERTAKER Sol Levinson & Bro

ADDRESS 1127 E Baltimore

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 20549

## CERTIFICATE OF DEATH.

REGISTERED NO. E 20549

1-PLACE OF DEATH

City of BALTIMORE: (No. 811 S. Clinton St. 76-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Thamer

(a) RESIDENCE NO. 811 S. Clinton St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Joseph Thamer

6 DATE OF BIRTH (month, day, and year) Feb 13/81

7 AGE: Years 46 | Months 1 | Days 9 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) City

(State or country)

PARENTS

10 NAME OF FATHER John Biggerman

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Anna

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Chas. Biggerman

(Address) 2018 Oakdale St.

15 Filed MAR 25 1927 16 C. HARRISON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/22/27 19

17 I HEREBY CERTIFY, That I attended deceased from 3/14 19 27, to 3/22/27, 19 27, that I last saw h... alive on 3/22/27, 19 27, and that death occurred, on the date stated above, at 9:30 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Sign

(Signed) Leamon Dwight, M. D.

, 19 27 (Address) 338 E Pat Pk Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mathews Date of Burial 3/25 19 27

20 UNDERTAKER Philip Henrig ADDRESS 2016 Orleans

(Do not abbreviate. Use ordinary figures. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.)

Spec.—12-9-25—A Co.—200 Bks.

# E 20550

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 E 20550

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St., 18-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Brooks Garner (Garner Brooks)

(a) RESIDENCE NO. Schroeder & Lexington sts. St. Res 745 Sarah Ann Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | Widower |

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1847

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 80 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Junk dealer

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) .....

(State or country) Virginia

PARENTS

10 NAME OF FATHER Robert Garner

11 BIRTHPLACE OF FATHER (city or town) .....

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed ..... 19 ..... T. HAMPSON JONES, M. D.

MAR 25 1927

Per K.M. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22, 1927 19

17

I HEREBY CERTIFY, That I attended deceased from March 5 19 27, to March 22, 19 27,

that I last saw h... alive on March 22, 19 27,

and that death occurred, on the date stated above, at 5.40 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

9

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....

(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) W. B. Gallent, M. D.

3-22-27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Mt. Zion Cemetery — Mar 25, 1927

20 UNDERTAKER — ADDRESS 322

Mrs. Katie R. Williams — N. Schroeder St

STATE EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20551

## CERTIFICATE OF DEATH

31

E 20551

1-PLACE OF DEATH

City of BALTIMORE: (No. Windsor Mill Rd. St. Hillsdale was formerly Rd. 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence Alvin Hoddinott

(a) RESIDENCE NO. Windsor Mill Road St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances A. Hoddinott

6 DATE OF BIRTH (month, day, and year) Oct. 9, 1885

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|---|
| | 41 | 5 | 14 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Auditor

(b) General nature of industry, business, or establishment in which employed (or employer) U. S.

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER John K. Hoddinott

11 BIRTHPLACE OF FATHER (City or town)

(State or country) W. Va.

12 MAIDEN NAME OF MOTHER Martha Fogler

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Mrs. Frances A. Hoddinott

(Address) Windsor Mill Road

15 Filed MAR 25 1927 C. HAMPSON JONES, M. D. Registrar

Per R M

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25, 1927

17 I HEREBY CERTIFY, That I attended deceased from March, 1924 to March 25, 1927

that I last saw h[illegible] alive on March 25, 1927

and that death occurred, on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. C. Lemmon, M. D.

(Address) March 25, 1927 430 E. Belvedere Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| London Park Cemetery | Mar 26 1927 |
| 20 UNDERTAKER John F. Denny | ADDRESS 715 Light St |

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20552

E 20552

## CERTIFICATE OF DEATH.

101-001

REGISTERED NO. 2643

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST., 25th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William E Jordan

(a) RESIDENCE NO. Mt Hope Retreat ST., 25th WARD Columbia S.C.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mch 23. 1863

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 64 | — | 1 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Morrison N. C.

PARENTS

10 NAME OF FATHER D. E. Jordan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Person N. C.

12 MAIDEN NAME OF MOTHER Cornelia E Gifford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cape Cod Mass.

14 Informant Records Mt Hope (Address) Mt Hope Md.

15 Filed MAR 23 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1926 to Mch 24, 1927, that I last saw him alive on Mch 23, 1927, and that death occurred, on the date stated above, at 12:50 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Chronic Emphysematis (duration) Unknown mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) C. B. Ewer, M. D.

3-27-1927 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Timmsboro S.C.

DATE OF BURIAL Mar 29 1927

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

NATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 20553

## CERTIFICATE OF DEATH.

E 20553

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 2108 Vine St. 70-69 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Flora. B. Livingston

(a) RESIDENCE NO. 2108 Vine St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. 6 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 ~~Single, Married, Widowed,~~ or Divorced, (~~write the word~~): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 3 1894

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 32 | 6 | 23 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Baltimore

PARENTS

10 NAME OF FATHER Wm. E. Atwood ~~Koch~~

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Ella. E. Dawes

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Baltimore Md

14 Informant Mrs Ella. E. Johns

(Address) 2108 Vine St

15 Filed MAR 25 1927 H. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 24 1927

17

I HEREBY CERTIFY, That I attended deceased from 3/15/27, 19..., to 3/23, 1927,

that I last saw h.. alive on 3/23, 1927,

and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) ... yrs. ... mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted ✓

If not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Clinical

3/25/27 (Signed) E Heller Hennessy M. D.

19 (Address) 700 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem — Date of Burial: Mar 26 1927

20 UNDERTAKER: Jos Joerdens Son — ADDRESS: 217 S. Pace

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 20554

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 20554
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hospital ST., 6-11 WARD)

2-FULL NAME Francis H Carr.

(a) RESIDENCE NO. 2556 W Baltimore ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. 1 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs F H Carr.

6 DATE OF BIRTH (month, day, and year): Feb 13, 1876

7 AGE

| Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|
| 51 | 1 | 12 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired 032

(b) General nature of industry, business, or establishment in which employed (or employer): Fire Department

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Francis H. Carr

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Emily Penny

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Hospital Records.
(Address)

15 Filed MAR 25 1927, 19 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 25 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 14, 1927, to March 25, 1927, that I last saw h~~im~~live on March 25, 1927, and that death occurred, on the date stated above, at 6.35 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
(Decompensation)
(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary): Pulmonary Oedema
(duration) yrs. 12 mos. 12 ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

DATE OF BURIAL: Mar 28 1927

20 UNDERTAKER: George J Smith

ADDRESS 1532 Holliday St

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20555

## CERTIFICATE OF DEATH.

100-001

E 20555

REGISTERED NO.

1-PLACE OF DEATH Balto City Hospls. 18-26

City of BALTIMORE: (No. Balto Md. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria T. Smith

(a) RESIDENCE NO. Home for Aged, Lexington & Calhoun Sts.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 9 1851

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 75 | 6 | 15 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Unknown

14 Informant: Balto City Hospls.

(Address): Balto Md.

Filed ..... 19..... Registrar

C. HAMPSON JONES, M. D.

MAR 25 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 3-24 27

17 I HEREBY CERTIFY, That I attended deceased from 2-3, 1927 to 3-24, 1927, that I last saw her alive on 3-24, 1927, and that death occurred, on the date stated above, at 7.35 P. m.

The CAUSE OF DEATH* was as follows:

Terminal Bronchopneumonia

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Senile Psychosis w/ Deterioration

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Henry J. Cloward M. D.

, 19 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem — Date of Burial: Mar 26 19 27

20 UNDERTAKER: Geo. J. Smith — ADDRESS: 1532 Hollins

REMEMBER: THE CAUSES SHOULD STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 20556

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31

E 20556

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [illegible] St. 70-69 Ward)

2-FULL NAME Eugene H Scott

(a) RESIDENCE NO. 2696 Wilkens Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 10th 1869

7 AGE: Years 57 | Months 11 | Days 13 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Electrician

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: [illegible] Tel & Tel Co

9 BIRTHPLACE (city or town):

(State or country): Maryland

PARENTS

10 NAME OF FATHER: William Scott

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Maryland

12 MAIDEN NAME OF MOTHER: Alice R. Stiles

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Maryland

14 Informant

(Address): Records

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D.
Registrar

Per [illegible]

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 23 1927

17

I HEREBY CERTIFY, That I attended deceased from March 22 1927, to March 23, 1927, that I last saw him alive on March 23, 1927, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Old Fibroid T.B.C. w/ Apices
Lobular Pneumonia

(duration) ..... yrs. ..... mos. ? ds.

CONTRIBUTORY (Secondary): Myocardial Failure

(duration) ..... yrs. ..... mos. ? ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? general & Laboratory

(Signed) R. Hoopes Smith, M. D.

March 24 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem Date of Burial: March 26 1927

20 UNDERTAKER: Joseph B Cook ADDRESS: 1003 W. Lafayette Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20557

## CERTIFICATE OF DEATH.

31 E 20557

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2531 E. Oliver ST. 8-16 WARD)

2-FULL NAME William L. Ford.

(a) RESIDENCE No. 2531 E. Oliver ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 ~~Single~~ Married, Widowed, ~~or Divorced~~ (write the word) |
|---|---|---|
| Male | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Clara. Ford.

6 DATE OF BIRTH (month, day, and year) August 9. 1858

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min |
|---|---|---|---|---|
| | 68 | 7 | 14 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER William L. Ford.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Virkman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant William O. Ford.

(Address) 2531 E. Oliver St.

15 Filed MAR 25 1927 16 C. HAMPTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23, 1927

17 I HEREBY CERTIFY, That I attended deceased from January 1, 1927 to March 23, 1927.

that I last saw him alive on March 23, 1927

and that death occurred, on the date stated above, at 11.40 P.M.

The CAUSE OF DEATH* was as follows:

Pthisis Pulmonalis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Laboratory tests

(Signed) Talbott Symmonds, M. D.

3/24/1927 (Address) 1613 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: March 26 1927

20 UNDERTAKER: George J. Ruetz — ADDRESS: 1735 Harford Ave.

TION is very important See instructions on back of certificates.

Spec—12-9-25—A Co.—200 Pks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20558

E 20558

90

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St. 72-30 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Commodore

(a) RESIDENCE NO. 704 Hanover St. Ward

(Usual place of abode) ?

(If non-resident give city or town and State)

Length of residence in city or town where death occurred . yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | Negro | ? |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1893

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 34 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labourer

(b) General nature of indnstry, bnsiness, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER Major Commodore

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant

(Address) [illegible] Rounds

15 Filed [illegible] 19

[illegible] Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21 1927

17

I HEREBY CERTIFY, That I attended deceased from March 13, 1927, to March 21, 1927, that I last saw him alive on March 21, 1927, and that death occurred, on the date stated above, at 10.45 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Myocardial Hypertrophy

(duration) yrs. 2 mos. 3 ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) yrs. mos. 3 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? General & laboratory

(Signed) [redacted] Hodges Smith, M. D.

March 27 1927 (Address) [redacted]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemty — Date of Burial: Mar 25 1927

20 UNDERTAKER: Lathie Gross — ADDRESS: 1485 McElderry

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAR 25 1927

C. HAMILTON JONES, M. D.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

50 E 20559
REGISTERED NO.

~~50~~ 273 E 20559
1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hollis Potter

(a) RESIDENCE NO. Groton - N - Y - St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of: Martha Potter

6 DATE OF BIRTH (month, day, and year): Unknown.

7 AGE: Years 43; Months; Days; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farm Manager

(b) General nature of industry, business, or establishment in which employed (or employer): 075

(c) Name of employer

9 BIRTHPLACE (city or town): N - Y -

(State or country)

PARENTS

10 NAME OF FATHER: Wilson Potter

11 BIRTHPLACE OF FATHER (city or town): N - Y -

(State or country)

12 MAIDEN NAME OF MOTHER: Eliza Hollis

13 BIRTHPLACE OF MOTHER (city or town): N - Y -

(State or country)

14 Informant: Friends -

(Address): JOHNS HOPKINS HOSPITAL

15 Filed MAR 25 1927 19 E. HAMPDEN JONES M. D. Registrar

Per RR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 24 1927

17

I HEREBY CERTIFY, That I attended deceased from March 17, 1927, to March 24, 1927, that I last saw him alive on March 24, 1927, and that death occurred, on the date stated above, at 9 A.M. p. m.

The CAUSE OF DEATH* was as follows:

Spinal Cord Tumor - (Cancer)

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Pulmonary Embolism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3/19/27

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) George L. Tumen M. D.

3/26/27 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cartland N Y — Date of Burial 3/25/27

20 UNDERTAKER: Joseph Ahrens — ADDRESS: 221 Bway

Cor.—12-9-25—A Co.—200 Bks.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. PHYSICIANS should state CAUSE

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 20560

188-003

E 20560

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Franklin Square Hospital 19-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jas. Gaines

(a) RESIDENCE NO. 525 N. Stricker St St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | Col'd. | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Baines

6 DATE OF BIRTH (month, day, and year) November 1888

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 38 | 6 4 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Mixing concrete

(c) Name of employer Mr. Benson Cont.

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER Orron Gaines

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Laura Villaims

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Sam Gaines 810 Parish St

(Address)

15 Date Received MAR 25 1927 C. HAMPSON JONES, M. D. Registrar

Per

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) March 22 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) Investigation that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured pelvis

Injured 3/5/27 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia (duration) mos. ds.

Med'd 25 1927 Thos. B. Norton M. D. (Coroner)

(Address) 1 Cedar St Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Stone Date of Burial March 27

20 UNDERTAKER Leonard Wade ADDRESS 3-4 Myrtle Ave

Spec.—12-9-25—A Co.—200 Bks.

# E 20561

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

# E 20561

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfred Hart (Bielfeldt)

(a) RESIDENCE NO. 307 S. Sharp st. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Separated |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1872

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 55 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chef

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER William Hart

11 BIRTHPLACE OF FATHER (city or town) Balto.

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Balto.

(State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed C. HAMPSON JONES, M. D.

Per Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22, 1927

17 I HEREBY CERTIFY, That I attended deceased from March 19, 1927, to March 22, 1927,

that I last saw h im alive on March 22, 1927,

and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. E. Gatlett, M. D.

3-23-1927 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Old Point Comfort Va | 3/25 1927 |

20 UNDERTAKER J J Doherty & Son ADDRESS 1318 Light

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAR 25 1927

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 20562 (66) E 20562

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1254 Riverside Ave. St. 23-31 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Peter Purcell.

(a) RESIDENCE NO. 1254 Riverside Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male. | White. | Single. |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 60 | -------- | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor.

(b) General nature of industry, business, or establishment in which employed (or employer) American Sugar refinery.

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Ireland.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Do not know.

14 Informant Mary Pomeroy.

(Address) 1254 Riverside Ave.

15 Filed 2 8 1927 C. HAMPSON JONES, M. D. Registrar

Per ARH

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

(duration) .....yrs. .....mos. .....ds.

(Signed) Otto Reinhardt M. D. (Coroner)

3/23, 1927 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death .....yrs., .....mos., .....ds. In the State .....yrs., .....mos., .....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Holy Cross A & C | 3/28 1927 |
| 20 UNDERTAKER | ADDRESS |
| John J. Lahey & Sons | 1318 Light St. |

Spec.—1-12-23—M&T—500 Blks.

E 20563

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20563

## CERTIFICATE OF DEATH.

467

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 774 Linnard St. 16-67 WARD)

REGISTERED NO

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ELLA. C. JOHNSON.

(a) RESIDENCE NO. 774 LINNARD ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. 0 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of, George D. Johnson.

6 DATE OF BIRTH (month, day, and year) Feb. 26. 1869

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min |
|---|---|---|---|---|
| | 59 | 0 | 26 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER Hugh Rogan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Co. Mayo Ireland.

12 MAIDEN NAME OF MOTHER Julia Rogan KELLY

13 BIRTHPLACE OF MOTHER (city or town) (State or country) County Mayo Ireland

14 Informant Edward McK. Johnson.

(Address) 709 Edmondson Ave

15 Filed MAR 26 1927 C. HAMPSON JONES, M. D.

Per RRR Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 24 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1926, to Mar. 24 1927, that I last saw her alive on Mar. 23, 1927 and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Dynamous called Epithelioma of cervix —

(duration) yrs. 6+ mos ds.

CONTRIBUTORY (Secondary) arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) Anthony V. Bucheneb, M. D.

, 19 (Address) 37 W. Strickers St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet

DATE OF BURIAL Mar 26th 1927

20 UNDERTAKER Henry H. Jenkins Sons Co

ADDRESS McCulloh & Eutaw Sts

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20564

E 20564

## CERTIFICATE OF DEATH

REGISTERED NO. 90

1-PLACE OF DEATH

City of BALTIMORE: (No. 1427 Hanover St. 23-32 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ethel D. Ross.

(a) RESIDENCE NO. 1427 Hanover St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 3 mos. 11 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female.

4 Color or Race: White.

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Alpheus J. Ross.

6 DATE OF BIRTH (month, day, and year): Dec, 13, 1888.

7 AGE — Years: 38, Months: 3, Days: 11.

IF LESS than 1 day ____ hrs. or ____ min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home. 37

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER: Daniel Lineberger

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Ella V. Clark.

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Md.

14 Informant: Alpheus J. Ross.

(Address): 1427 Hanover Street.

15 MAR 26 1927

16 C. HAMPSON JONES, M. D.

Per RPS Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Mar. 24 27

17 I HEREBY CERTIFY, That I attended deceased from Mar. 9, 1927, to Mar 24, 1927.

that I last saw her alive on Mar 24, 1927.

and that death occurred, on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Valvular heart disease

(duration) 2 yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. Hampson Jones, M. D.

3/25, 1927 (Address) 14 Randall St

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Auburn Cem. Date of Burial Mar 28 1927

20 UNDERTAKER A. Howard Evans ADDRESS 386 E. Fayette

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20565

E 20565

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 30 E. HAMBURG. 2-3-33 ST., WARD) 16-98

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME INFANT THOMPSON

(a) RESIDENCE NO. 30 E. HAMBURG. ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | WHITE | SINGLE |

5a If married, widowed, or divoreed
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) MARCH 25, 1927

| 7 AGE | Years | Months | Days | If LESS than 1 day, 3 hrs or 15 min. |
|---|---|---|---|---|
| | — | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) BALTO MD.

PARENTS

10 NAME OF FATHER BARTHOLEMEW THOMPSON

11 BIRTHPLACE OF FATHER (city or town) (State or country) BALTO MD.

12 MAIDEN NAME OF MOTHER LEONA BENSON

13 BIRTHPLACE OF MOTHER (city or town) (State or country) BALTO MD.

14 Informant MRS LEONA THOMPSON
(Address) 30 E HAMBURG ST

15 Filed MAR 26 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/25 1927

17

I HEREBY CERTIFY, That I attended deceased from MARCH 25. 1927. to MARCH 25. 1927.

that I last saw him alive on MARCH 25. 1927.

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Premature Gestation
(6½ months)

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home —

Did an operation precede death? NO Date of —

Was there an autopsy? NO —

What test confirmed diagnosis? SIGNS & SYMPTOMS —

(Signed) J. Ed Peterman, M. D.

, 19 (Address) 1285 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Cedar Hill Cem | March 26 1927 |

20 UNDERTAKER ..... ADDRESS Evans 28 E Fort Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 20566

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

9-46 29

E 20566

1-PLACE OF DEATH

REGISTERED NO._____

City of BALTIMORE: (No. 617 Montpelier St St. ____ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward B. Young

(a) RESIDENCE NO. 617 Montpelier St St. ____ Ward ____

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. ___ mos. ___ ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | divorced |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Young

6 DATE OF BIRTH (month, day, and year) March 26/62

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 64 | 11 | 26 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman 62

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Dietrick Bros

9 BIRTHPLACE (city or town)

(State or country) Penna

PARENTS

10 NAME OF FATHER Henry Young

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Pa

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Mrs Nettie Tisdale

(Address) 2616 1/2 Madison Ave

15 [illegible] 1927 C. HAMPSON JONES, M. D.

Par [illegible] Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 24/ 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Hypertrophy - Mitral Insuff

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) Chr Nephritis

(duration) ___ yrs. ___ mos. ___ ds.

(Signed) J. H. Pollitt, M. D.

(Coroner)

3/25/27 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakland Cemetery — Date of Burial 3/26 1927

20 UNDERTAKER William Cook — ADDRESS 502 E North

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20567

## CERTIFICATE OF DEATH.

167-E 20567

1-PLACE OF DEATH

City of BALTIMORE: (No. Louisiana Ave St. 12 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter A. Clark

(a) RESIDENCE NO. 3038 Abell Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Neva Clark.

6 DATE OF BIRTH (month, day, and year) Feb. 21 1867

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 60 | 1 | 4 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tire Dealer

(b) General nature of industry, business, or establishmeat in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) Penfield

(State or country) N.Y.

PARENTS

10 NAME OF FATHER Horace Clark

11 BIRTHPLACE OF FATHER (city or town)

(State or country) N.Y.

12 MAIDEN NAME OF MOTHER Ann Burns

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) N.Y.

14 Informant Mrs. Neva Clark

(Address) 3038 Abell Ave

15 Filed 2 1927 19 C. HAMPSON JONES, M. D. Registrar

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 25 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to h... death on the day stated above.

The CAUSE OF DEATH* was as follows: Gas Poisoning Suicide

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) C. Hampson Jones M. D. (Coroner)

3/26, 19 27 (Address) 3672 Roland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Phelps N.Y. | Mar. 26, 27 |

| 20 UNDERTAKER | ADDRESS |
|---|---|
| Wm Tickner & Sons | North & Pa |

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20568

## CERTIFICATE OF DEATH.

185 E 20568

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hosp St. 4-25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clayton D Duty

(a) RESIDENCE NO. 301 N. Green St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Bettie Duty

6 DATE OF BIRTH (month, day, and year): Nov 22 03

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 23 | 4 | 7 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter helper

(b) General nature of industry, business, or establishment in which employed (or employer): 584

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country): Va.

PARENTS

10 NAME OF FATHER: C. Duty

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country): Va.

12 MAIDEN NAME OF MOTHER: Williams

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country): Va.

14 Informant: Bessie E Duty

(Address) 708 N Fulton

Mar 26 1927 C. HAMPSON JONES, M. D.

Per _____ Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 25 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract. Fracture skull

Shock. (Some hours)

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) (over)

(duration) .....yrs. .....mos. .....ds.

(Signed) W. S. Thing M. D.

(Coroner)

Mch 27, 1927 (Address) 1032 Druid

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Alexandria Va

Date of Burial: Mar 26 1927

20 UNDERTAKER: H M Routon

ADDRESS 2238 N Howard

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 20569

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20569

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 3513 Newland Street St. 12-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Louis Volkmar

(a) RESIDENCE NO. 3513 Newland Street St. 12 Ward Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. 4 mos. 5 ds. How long in U. S. If of foreign birth 83 yrs. 4 mos. 5 ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Nov-20-1843

| 7 AGE | Years | Months | Days | IF LESS than 1 day ... hrs. or ... min.. |
|---|---|---|---|---|
| | 83 | 4 | 5 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER George D. Volkmar

11 BIRTHPLACE OF FATHER (City or town) ? ?

(State or country) Germany

12 MAIDEN NAME OF MOTHER Louisa Burkhart

13 BIRTHPLACE OF MOTHER (city or town) ? ?

(State or country) Germany

14 Informant Mr. Charles A. Volkmar (brother)

(Address) 3513 Newland Street

15 Filed ... 19 ... C. HAMPSON JONES, M. D.

Per ... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 March 25

17 I HEREBY CERTIFY, That I attended deceased from Mar 21 1927 to Mar 25 1927

that I last saw him alive on Mar 25 1927

and that death occurred, on the date stated above, at 5.20 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Benj. F. Phillips M. D.

Mar 26 1927 (Address) 832 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Druid Ridge Cemetery | Mar-28-1927 |
| 20 UNDERTAKER | ADDRESS |
| STEWART & MOWEN COMPANY (Successor) | 1001 N. NORTH AVE. |

MAR 26 1927

Per KMA

All blanks must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20570

## CERTIFICATE OF DEATH

90 E 20570

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 2923 N. Charles Street St. 12-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Atlanta Tide Rice

(a) RESIDENCE NO. 2923 N. Charles Street St. 12 Ward Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 7 mos. 6 ds. How long in U. S. if of foreign birth 60 yrs. 7 mos. 6 ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lewis C. Rice

6 DATE OF BIRTH (month, day, and year): August-17-1866

| 7 AGE | Years | Months | Days | IF LESS than 1 day... hrs. or ... min.. |
|---|---|---|---|---|
| | 60 | 7 | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town): Baltimore

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Oliver McCubbin

11 BIRTHPLACE OF FATHER (City or town): ? ?

(State or country): Penna.

12 MAIDEN NAME OF MOTHER: Amanda Shipley

13 BIRTHPLACE OF MOTHER (city or town): ? ?

(State or country): Penna.

14 Informant: Mr. Lewis C. Rice, (husband)

(Address): 2923 N. Charles Street.

15 Filed MAR 26 1927 16 C. HAMPSON JONES M. D. Registrar

Per APH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): MAR 24 1927

17 I HEREBY CERTIFY, That I attended deceased from MAR 20 1927, 19..., to MAR 24 1927,

that I last saw her alive on MAR 24 1927,

and that death occurred, on the date stated above, at 6.45 A. m.

The CAUSE OF DEATH* was as follows:

Probably Cerebral Hemorrhage or Embolism of Brain

(duration) X yrs. X mos. X 2 hours

CONTRIBUTORY (Secondary) Myocarditis and arterial hypertention

(duration) one yrs. X mos. X ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Otto F. Duncker M. D.

MAR 26 1927 (Address) 928 E. North

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — Date of Burial: Mar-26-27 19

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS: 108 W. NORTH AVE.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 20571

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20571

## CERTIFICATE OF DEATH.

159-27

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 617 Aldenshot Rd St. or Ave.) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Shanks

(a) RESIDENCE NO. 617 Aldenshot ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | single |

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3-24-27

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Robt Shank

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER India Lynch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant John Robt Shank
(Address) 617 Aldenshot Road

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES M.D.

3 26 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-25 1927

17 I HEREBY CERTIFY, That I attended deceased from 3-24, 1927, to 3-25, 1927,

that I last saw him alive on 3-25, 1927,

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Talent Foramen Oval
Partial Atelectasis

(duration) ... yrs. mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted — If not at place of death? ...

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) ..... M. D.

, 19 (Address) 4000 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem — DATE OF BURIAL Mar 26 1927

20 UNDERTAKER Josiah Syfer — ADDRESS Pratt & Paca

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20572

## CERTIFICATE OF DEATH.

31 E 20572

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 502 N. Montford St. 10 Ward)

2-FULL NAME Mary Caldella

(a) RESIDENCE NO. 502 N. Montford St. Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? 6 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 16 1911

7 AGE: 15 — Years: 14 — Months: 7 — Days: 9. — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER John Caldella

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Italy

12 MAIDEN NAME OF MOTHER Melina

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Italy

14 Informant: John Caldella

(Address) 502 N Montford Ave

15 Filed ..... 19 .....

C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 24 1927

17 I HEREBY CERTIFY, That I attended deceased from March 1 1927 to March 24, 1927,

that I last saw her alive on March 18, 1927

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. L. Passano M. D.

3.27. 1927 (Address) 517 Druid Park Lane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem. Date of Burial: Mar 28 1927

20 UNDERTAKER: Wm. C. Miller & Son ADDRESS: 2334 Gilmor St

0 1927

Rec

Be DEATH or birth cards, so that it may be properly classified. Exact statement of OCCUP. is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20573

## CERTIFICATE OF DEATH.

11-6 2

E 20573

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2127 E Lombard ST. 1-3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John T. Barber

(a) RESIDENCE No. 2127 E. Lombard ST., 2 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widower |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret M. Barber

6 DATE OF BIRTH (month, day, and year) Nov 17 1845

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 82 | 4 | 7 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Court Bailiff (Retired)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Michael Barber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Catherine Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Easton Md.

14 Informant Mrs Mary. Barber

(Address) 2127 E Lombard St

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M.D.

MAR 25 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24 1927

17 I HEREBY CERTIFY, That I attended deceased from March 14, 1927, to March 24, 1927, that I last saw him alive on March 24, 1927, and that death occurred, on the date stated above, at 11:30 A m.

The CAUSE OF DEATH* was as follows:

Influenza (epidemic)

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Cancer - exhibition of heart & edema of lungs

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Henry B Hebey, M. D.

3/25, 1927 (Address) 2504 W Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| London Park Cem. | March 26 1927 |
| 20 UNDERTAKER | ADDRESS |
| H. Allen Fuller | 37 Collins Pl |

INSTRUCTIONS—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20574

## CERTIFICATE OF DEATH.

101-001

E 20574

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Mercy Hospital

City of BALTIMORE: (No. _____ St. 26 Ward)

2-FULL NAME George William Berlett

(a) RESIDENCE NO. 4901 First Ave St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Barbara Berlett

6 DATE OF BIRTH (month, day, and year): March 19th 1865

7 AGE: Years 62. Months — Days 5 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Wheelwright 007

(b) General nature of industry, business, or establishment in which employed (or employer): Retired 1½ Years

(c) Name of employer

9 BIRTHPLACE (city or town): Unknown

(State or country): Germany

PARENTS

10 NAME OF FATHER: George W. Berlett

11 BIRTHPLACE OF FATHER (city or town): Unknown

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Plenger

13 BIRTHPLACE OF MOTHER (city or town): Unknown

(State or country): Germany

14 Informant: Barbara Berlett

(Address) 4901 First Ave.

15 Filed 2 6 1927 C. HAMPSON JONES, M. D.

Registrar

By _____

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 24 1927

17 I HEREBY CERTIFY, That I attended deceased from March 21 1927, to March 24 1927, that I last saw h alive on March 24 1927, and that death occurred, on the date stated above, at 5.00 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. G. Motta, M. D.

, 19 (Address) Mercy Hospital Cit

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Iron Lutheran Cemetery Date of Burial: March 27th 29

20 UNDERTAKER: Frederick Lassahn & Sons ADDRESS: Fullerton

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20575

## CERTIFICATE OF DEATH.

31 E 20575

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospitals Ward 22-30)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chooler Sammer

(a) RESIDENCE NO. 623 W Balto St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 Color or race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE: Years 46 | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany

(State or country)

10 NAME OF FATHER Jacob Sammer

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Lambert

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

* PARENTS

14 Informant Husband

(Address) Same

15 Filed 1927 C. HAMPSON JONES, M. D.

Per ARH Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

3-23-27

17 I HEREBY CERTIFY, That I attended deceased from 3-19- 1927, to 3-23, 1927, that I last saw him alive on 3-23, 1927 and that death occurred, on the date stated above, at 2 30 p.m.

The CAUSE OF DEATH* was as follows:

Bilateral Pulmonary Tuberculosis

(duration) mos. ds.

CONTRIBUTORY (Secondary) Acute Appendicitis and Peritonitis (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of 3-19-27

Was there an autopsy? Yes

What test confirmed diagnosis? Physical Signs & Sputum

(Signed) J. Blackwell M. D.

, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western — Date of Burial Mar 24 1927

20 UNDERTAKER John J. Fulda — ADDRESS 1200 W Lombard

very important. See instructions on back of certificates.

Spec.–7-17-26–A Co.—200 Bks.

20576

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 20576

## CERTIFICATE OF DEATH

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 1111 Gilmore St 16-22 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Emma Johnson

(a) RESIDENCE NO. 1111 Gilmore St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 8-16 1902

7 AGE: Years 24 Months 7 Days 8 IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer Self

9 BIRTHPLACE (city or town) Baltimore md

(State or country)

PARENTS

10 NAME OF FATHER Henry Johnson

11 BIRTHPLACE OF FATHER (City or town) Shaw's md.

(State or country)

12 MAIDEN NAME OF MOTHER Ella Chase

13 BIRTHPLACE OF MOTHER (city or town) Chase's md.

(State or country)

14 Informant mother

(Address) 1111 Gilmore St

15 1927 C. HAMPSON JONES, M. D.

Per ..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-24 1927

17 I HEREBY CERTIFY, That I attended deceased from 3-20, 19.., to 3-29, 19..,

that I last saw h.. alive on 3-29, 19..,

and that death occurred, on the date stated above, at 7:30 P. M.

The CAUSE OF DEATH* was as follows:

Bilateral bronchopneumonia

(duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary) Exposure

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Jno. R. Saunders, M. D.

, 19 (Address) 1029 N. Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Peter's R. C. cemetery — Date of Burial: Mar. 28, 1927

20 UNDERTAKER: Mrs Katie R. Williams — ADDRESS 322 N. Schroeder St

26 1927

THIS SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 20577

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

101-004

E 20577

1-PLACE OF DEATH

City of BALTIMORE: (No. 242 N Amity St. 18-26 Ward)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas. H. Tankard

(a) RESIDENCE NO. 242 N. Amity St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced (write the word): Mar

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary L. Tankard

6 DATE OF BIRTH (month, day, and year): 1864

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 63 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Porter

(b) General nature of industry, business, or establishment in which employed (or employer): _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) Va

(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) unknown

14 Informant Mary L Tankard

(Address) 242 N Amity

15 Filed MAR 26 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch. 24 1927

17 I HEREBY CERTIFY, That I attended deceased from Mch 23, 1927, to Mar 24, 1927, that I last saw him alive on Mar 24, 1927, and that death occurred, on the date stated above, at 6 20 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) _____ yrs. _____ mos. 5 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) _____ yrs. _____ mos. ✓ ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? No Date of No

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) 2/7/27 J J Mooney, M. D.

Mch 19 (Address) 937 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — Date of Burial: Mar 28, 1927

20 UNDERTAKER: Mrs. Kate R. Williams — ADDRESS 322 N. Schroeder St.

If the space provided is insufficient, as it may be in many cases, the information required will be very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20578

100-00 E 20578

## CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Mercy Hospital

City of BALTIMORE: (No._____ St. 20-69 Ward)

2-FULL NAME Baby Maria Rita Pesaro

(a) RESIDENCE NO. 2401 Lauretta Ave. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): S.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): April 20th 1926

7 AGE — Years | Months: 11 | Days: 5 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town): Balto

(State or country): Md

PARENTS

10 NAME OF FATHER: Fred Pesaro

11 BIRTHPLACE OF FATHER (city or town): Italy

(State or country)

12 MAIDEN NAME OF MOTHER: Alfia Tena

13 BIRTHPLACE OF MOTHER (city or town): Italy

(State or country)

14 Informant: Fred Pesaro

(Address): 2401 Lauretta Ave

15 Date Rec'd: 6 1927 Filed

C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 25 1927

17 I HEREBY CERTIFY, That I attended deceased from March 22, 1927, to March 25, 1927, that I last saw h... alive on March 25, 1927, and that death occurred, on the date stated above, at 4:20 p. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (Cong)

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — Date of Burial: March 28 1927

20 UNDERTAKER: Frank V. Fitzstone — ADDRESS: 1515 E Balto St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE E 20579

E 20579

## CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1408 - Born St ST. 19-27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Sneed

(a) RESIDENCE NO. 1408 Born St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. 7 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | Negro | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 1876

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 51 | unknown | unknown | |

8 OCCUPATION OF DECEASED

040

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) General Labor

(c) Name of employer employer

9 BIRTHPLACE (city or town) (State or country) Town Md

PARENTS

10 NAME OF FATHER Wesley Sneed

11 BIRTHPLACE OF FATHER (city or town) (State or country) Town Md

12 MAIDEN NAME OF MOTHER Catherine Sneed

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Town Md

14 Informant Laura Smith (niece)

(Address) 1408 Born St.

15 Filed 6 1927 C. HAMPSON JONES, M. D. Registrar

By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/25 1927

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1926 to Aug 25, 1927

that I last saw h alive on Aug 24, 1927

and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH was as follows:

Ca Intestines Hepatic

(duration) 1 yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis.

(duration) yrs. 6 mos. 0 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? Date of

Was there an autopsy? No Observed

What test confirmed diagnosis? Exp. Unknown

(Signed) Addie J Hoffman M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL Mch 28 1927

20 UNDERTAKER A. Jones

ADDRESS 1115 Gilmor

TION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20580

## CERTIFICATE OF DEATH

10 E 20580

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 1200 Longwood St., 16-67 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jean Estelle Hertz.

(a) RESIDENCE NO. 1200 Longwood St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 4 1924

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min.. |
|---|---|---|---|---|
| | 2 | 5 | 21 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER David E Hertz

11 BIRTHPLACE OF FATHER (City or town) Ga.

(State or country)

12 MAIDEN NAME OF MOTHER Esther L Stark

13 BIRTHPLACE OF MOTHER (city or town) Ga.

(State or country)

14 Informant David E Hertz

(Address) 1200 Longwood St

15 Filed 2 6 1927 Per

16 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 1927

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1927, to March 25, 1927, that I last saw her alive on March 25, 1927, and that death occurred, on the date stated above, at 8.45 a.m.

The CAUSE OF DEATH* was as follows:

Diphtheria

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Heart Failure

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

3/26/27 (Address) 709 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Loudon Park Cem | Mar 26 1927 |
| 20 UNDERTAKER Joseph B Cook | ADDRESS 1003 N Gay St |

Be sure all items are properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE E 20581

E 20581

## CERTIFICATE OF DEATH.

109-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2226 Fleet st. St. 1-3 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maryanna Grabecka.

(a) RESIDENCE NO. 2226 Fleet st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (Write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Aug 16 – 1911

7 AGE: Years 15 Months 7 Days 8 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School. 200

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto md.

PARENTS

10 NAME OF FATHER: Stanislaw Grabecki

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland.

12 MAIDEN NAME OF MOTHER: Rozalia Kedrzejewska

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto md.

14 Informant (Address): Stanislaw Grabecki 2226 Fleet st.

15 Filed 2 6 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/24 1927

17 I HEREBY CERTIFY, That I attended deceased from 1-15 1927, to 3-24 1927,

that I last saw her alive on 3/24 1927,

and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH* was as follows:

Septic Sore Throat

Influenzas arthritis

Myocarditis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Daniel A. Dugan M. D.

1927 (Address) 3125 Patterson a

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus

DATE OF BURIAL: March 28 1927

20 UNDERTAKER: George A. Weber

ADDRESS: 2205 Bank st.

TION is very important. See instructions on back of certificates.

(Holt)

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20582 ~~E 20582~~

## CERTIFICATE OF DEATH

90

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 1122 N. Mount, Colonial Hosp. St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jno. Stobe.

(a) RESIDENCE NO. 232 W. Biddle St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ? 1880

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 47 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town) Unknown

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown

(State or country)

14 Informant Mrs. Gardner

(Address) 232 W. Biddle St.

26 1927 C. HAMPSON JONES, M.D.

Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/24 1927

17 I HEREBY CERTIFY, That I attended deceased from 3/22 1927, to 3/24 1927, that I last saw h[illegible] alive on 3/24 1927 and that death occurred, on the date stated above, at 4:30P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia.

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis.

(duration) ? yrs. mos. ds.

18 Where was disease contracted ?

If not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Signs

(Signed) John W. Staton M. D.

, 19 (Address) Colonial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — Date of Burial 3/26/27

20 UNDERTAKER Mrs. Geo. H. Holland — ADDRESS 1621 Druid Hill Ave

If not in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co.—1000 Bks.

E 20583

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20583

## CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH 3020 Abell Ave

CITY OF BALTIMORE: (No. John D. Kearney ST. 12-50 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John D. Kearney

(a) RESIDENCE. NO. 3020 Abel Av ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | W | married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 4 - 1871

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 55 | 8 | 20 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk Post Office

(b) General nature of industry, business, or establishment in which employed (or employer) U S.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Pat Kearney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Lyons

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Bridget Nora Kearney
(Address) 3020 Abel ave

15 Filed 6 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/24 1927

17 I HEREBY CERTIFY, That I attended deceased from June 1 1926 to March 24 1927.

that I last saw him alive on March 24 1927.

and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis (General)

(duration) Unknown yrs. ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. R. Goldsborough M. D.

, 19 (Address) 2923 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 3/28 1927

20 UNDERTAKER H. C. Brauning Son

ADDRESS 517 N Schroeder st

THIS is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20584 198 — E 20584

CERTIFICATE OF DEATH. + 37-001

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 7-9 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Lemax

(a) RESIDENCE NO. Forth Pt. Rd - Balto Co Ward Unk -
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4yr. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 23 1926

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | | 5 | 1 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Unk.
(State or country)

PARENTS

10 NAME OF FATHER Pat Lemax

11 BIRTHPLACE OF FATHER (city or town) Ga -
(State or country)

12 MAIDEN NAME OF MOTHER Fannie Reynolds

13 BIRTHPLACE OF MOTHER (city or town) Ga -
(State or country)

14 Informant Friends -
(Address)

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec. 20 1926, to March 24, 1927.

that I last saw him alive on March 24, 1927,

and that death occurred, on the date stated above, at 3 15 p. m.

The CAUSE OF DEATH* was as follows:

Miliary tuberculosis

(duration) ...yrs. 3 mos. ds.

CONTRIBUTORY
(Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted
If not at place of death

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? X ray, Tuberculin

(Signed) H. L. Handley, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ashury Cemetery Date of Burial March 26 1927

20 UNDERTAKER Mrs. R. L. Elliott ADDRESS 722 Ashland Ave

26 1927

very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20585

20585

## CERTIFICATE OF DEATH

161-001

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. University Hospital St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby. Girl. Robinson

(a) RESIDENCE NO. 1714 Webster St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | white | infant |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) mar. 20, 1927.

7 AGE Years Months Days IF LESS than 1 day 2 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) md

PARENTS

10 NAME OF FATHER Howard Jamar

11 BIRTHPLACE OF FATHER (City or town) Baltimore

(State or country) Md.

12 MAIDEN NAME OF MOTHER Elma Robinson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) md

14 Informant Mrs. Howard Baker

(Address)

15 Witness C. HAMPSON JONES, M. D.

16 Registrar

Per ACH

11 92

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 Mar. 20

17

I HEREBY CERTIFY, That I attended deceased from Mar 20, 1927, to Mar 20 1927.

that I last saw h alive on Mar 20 1927.

and that death occurred, on the date stated above, at 4:45 P.M.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Elizabeth Hamman, M. D.

, 19 (Address) Univ. hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

Date of Burial Mar 26 1927

20 UNDERTAKER Commissioner Health

ADDRESS

Rev. Wm. L. Woodall

MAR 26 1927

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

2E/20586 — 111-001 — E 20586

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSP St. 7-9 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Morris Kaplan

(a) RESIDENCE NO. 819 S. 14th St. St. Newark - N J -

(Usual place of abode) (If non-resident give city or town and state)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jennie Kaplan

6 DATE OF BIRTH (month, day, and year)

| 7 AGE Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|
| 43 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Upholsterer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Russia

(State or country)

PARENTS

10 NAME OF FATHER: Paul Thenzer

11 BIRTHPLACE OF FATHER (city or town): Ger —

(State or country): Russia

12 MAIDEN NAME OF MOTHER: Emma Pokrote

13 BIRTHPLACE OF MOTHER (city or town): Ger —

(State or country): Russia

14 Informant: Records —

(Address): JOHNS HOPKINS HOSPITAL

15 Filed: 1927 C. HAMPSON JONES, M. D.

Per WPH Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 26 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb 25, 1927, to March 26, 1927, that I last saw him alive on March 26, 1927, and that death occurred, on the date stated above, at 4 30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary): Gastric ulcer for years

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Mar 14

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) E. Cowell Frothingham, M. D.

Mar 26 1927 (Address) Johns Hopk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Newark N. J. Date of Burial 3/26 1927

20 UNDERTAKER: Jack Louis ADDRESS 1139 Eutaw St

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 20587

## CERTIFICATE OF DEATH.

E 20587
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. City Jail St., 4-29 Ward)

2-FULL NAME J. D. Zell

(a) RESIDENCE NO. 740 E. Lombard St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 5-0 Months about Days

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant

(Address) City Jail

15 1927 C. HAMPSON JONES, M. D.
Registrar

Per

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) March 22 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

4 days (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. W. Kelly M. D.
(Coroner)

, 19 (Address) 1659 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fort Wayne, Ind. Date of Burial 3/24/1927

20 UNDERTAKER: H. D. Fanning ADDRESS 1936 E. Lafayette Ave

Cor. 12-9-25—A Co.—200 Bks. HEALTH DEPARTMENT—CITY OF BALTIMORE. very important. See instructions on back of certificate. PART STATISTICAL OF OCCUPATION 18

Spec.—12-9-25—A Co.—200 Pks.

Beasley

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20588

CERTIFICATE OF DEATH.

101 E 20588

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2218 Durham St. 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Smith Beasley

(a) RESIDENCE NO. 2218 Durham St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: C

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James Beasley

6 DATE OF BIRTH (month, day, and year): May 6 1893

7 AGE: Years 33 | Months 10 | Days 18 | If LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Md

PARENTS

10 NAME OF FATHER: Unk

11 BIRTHPLACE OF FATHER (city or town)

(State or country): —

12 MAIDEN NAME OF MOTHER: Mary Stepney

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md

14 Informant: Ora Beasley

(Address): 2218 Durham St

15 Filed MAR 27 1927 Per C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 24 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 19 1927, to March 24, 1927, that I last saw h[illegible] alive on March 24, 1927, and that death occurred, on the date stated above, at 6:45 A m.

The CAUSE OF DEATH* was as follows:

Pleuropneumonia

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) George Fuller, M. D.

Mar 25 1927 (Address) 508 Somerset St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cemetery — Date of Burial: Mar 27 1927

20 UNDERTAKER: Robert E Williams — ADDRESS: 515 McElderry St

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20589

## CERTIFICATE OF DEATH.

66

E 20589

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 610 N. Calvert St. 11-7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Winn

(a) RESIDENCE NO. 610 N. Calvert St., St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE Mary E. Winn

6 DATE OF BIRTH (month, day, and year) Sept 18 - 1881

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 45 | 6 | 7 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman 462

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Patrick F. Winn

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland.

12 MAIDEN NAME OF MOTHER Ella N. Winn

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore

14 Informant Mary E. Winn

(Address) 2101 E. Calvert St.

15 Filed....., 19.. E. HAMPSON JONES, M. D. Registrar

MAR 27 1927 Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25th 1927

17 I HEREBY CERTIFY, That I attended deceased from March 24 1927, to March , 1927, that I last saw him alive on March 24 1927, and that death occurred, on the date stated above, at 1.30 a m.

The CAUSE OF DEATH* was as follows:

Acute alcoholism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Sheldon Eastland, M. D.

, 19 (Address) 2736 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery Date of Burial 3/28 1927

20 UNDERTAKER Chas. F. Hausleton ADDRESS 1181 Mt Royal Ave

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 20590 — REGISTERED NO. E 20590

1-PLACE OF DEATH

City of BALTIMORE: (No. 3807 Fenchurch St. 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Page Duer

(a) RESIDENCE NO. 3807 Fenchurch St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 10, 1864

7 AGE 62 Years 4 Months 16 Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 066

(c) Name of employer

9 BIRTHPLACE (city or town) Princess Anne

(State or country) Maryland

PARENTS

10 NAME OF FATHER Edward Franklin Duer

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Virginia White

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Virginia Rose McCormick

(Address) 3807 Fenchurch St.

15 Filed MAR 27 1927 19 C. HAMPTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 29, 1926, to March 25, 1927, that I last saw him alive on March 25, 1927, and that death occurred, on the date stated above, at 8:15 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

4

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

2

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar P. Sandrock, M. D.

19 (Address) 15 W. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Princess Anne Md — Date of Burial: March 28 1927

20 UNDERTAKER: Henry H. Jenkins Sons Co. — ADDRESS: Crisfield Md

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20591

## CERTIFICATE OF DEATH.

E 20591

1-PLACE OF DEATH Mercy Hospital

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. 425 WARD)

2-FULL NAME Joseph Colasurda

(a) RESIDENCE (No. 115 N. Mulberry St ST., ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W. | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 3 1893

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 34 | 11 | 23 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Furrier

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mono Smalz

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Maurice Colasurda

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Maria Colovito

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Petro Colasurda

(Address) 1116 Calhoun St.

15 Filed MAR 27 1927, 19 C. HAMPSON JONES, M. D. Registrar

Per .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 26 19 27

17

I HEREBY CERTIFY, That I attended deceased from March 18, 1927, to March 26, 1927, that I last saw h[illegible] alive on March 26, 1927, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Myocardial failure

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Acute Nephritis & Uremia

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) H. Smolla, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery DATE OF BURIAL Mar 28 1927

20 UNDERTAKER J. McCook ADDRESS 502 E. Baltimore

TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

20407 Lung. 4.45 P.M.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

× 84 E 20592

1-PLACE OF DEATH E 20592

REGISTERED NO._____

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 79 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mae Hansford

(a) RESIDENCE NO. Spotsylvania Va St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | white | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 12, 1904

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 23 | 0 | 14 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Spotsylvania

(State or country) Va

PARENTS

10 NAME OF FATHER Wm Hansford

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va.

12 MAIDEN NAME OF MOTHER Myrtle Shaw

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va.

14 Informant Friends

(Address) Johns Hopkins Hospital

C. HAMPSON JONES, M. D.

Filed APR 27 1927 Per _____ Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

March 26th 1927

17

I HEREBY CERTIFY, That I attended deceased from March 22nd 1927, to March 26th, 1927,

that I last saw h.. alive on March 26th, 1927,

and that death occurred, on the date stated above, at 4.45 P m.

The CAUSE OF DEATH* was as follows:

Brain Tumor — Cerebellar (Benign)

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of March 26th 27

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) George E Finney, M. D.

3/26/27 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fredericksburg, Va Date of Burial March 27 1927

20 UNDERTAKER Wm Cook ADDRESS 527 E Fairmount Ave

very important. See instructions on back of certificates.

Spcl. -7-17-26—A Co.—200 Bks.

E 20593

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

129 E 20593

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 816. S. Bond. St. 3-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Mros

(a) RESIDENCE NO. 816. S. Bond St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Vincent. Mros

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 46 Months Days: About

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Homework

(b) General nature of industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Maciej Bolcer

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Frances Kozlowsky

13 BIRTHPLACE OF MOTHER (City or town)

(State or country) Germany

14 Informant: Vincent Mros

(Address) 816 S. Bond St

15 Filed MAR 27 1927 19 HAMILTON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/24 19 27

17 I HEREBY CERTIFY, That I attended deceased from 3/17, 19 27, to 3/24, 19 27

that I last saw her alive on 3/21, 19 27

and that death occurred, on the date stated above, at 6. A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis Asthma

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Pneumonia & Pleural fracture

(duration) yrs. mos. 4 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? N U Date of

Was there an autopsy? N U

What test confirmed diagnosis? Signs & symptoms

(Signed) Ludwig N Bruckner, M. D.

. 19 (Address) 1623 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — Date of Burial: 3/28 1927

UNDERTAKER: Wm Fiallowski — ADDRESS: 1618 Eastern Ave

Be sure to write in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 20594

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

129 E 20594

1-PLACE OF DEATH

REGISTERED NO. 4-225

City of BALTIMORE: (No.) 648 W Fairmount Ave (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Naomi Murray

(a) RESIDENCE NO. 648 W Fairmount Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Alfred Murray

6 DATE OF BIRTH (month, day, and year): March 15-1889

7 AGE — Years: 38 — Months: — Days: 12 — IF LESS than 1 day ... hrs. or ... min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (City or town): Balto.

(State or country): Md

PARENTS

10 NAME OF FATHER: James Johnson

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Md

12 MAIDEN NAME OF MOTHER: Ellen Powell

13 BIRTHPLACE OF MOTHER (City or town):

(State or country): Md.

14 Informant: Alfred Murray

(Address) 648 W. Fairmount Ave.

Filed MAR 27 1927 19 C. HAMPSON JONES, M. D., Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24 1927

I HEREBY CERTIFY, That I attended deceased from January 2 1927 to March 24 1927, that I last saw h[e] alive on March 24 1927, and that death occurred, on the date stated above, at 1:30 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis Endocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) [illegible] M. D.

3/26/ 1927 (Address) 419 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem.

Date of Burial: 3/27/ 1927

20 UNDERTAKER: Samuel L Kinsley

ADDRESS: W Balto

very important. See instructions on back of certificate. Every statement must be answered. Exact statement of OCCUPATION is

Spec.–7-17-26—A Co.—200 Bks.

20595

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

74-001

E 20595

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 29 Russell St. Ward 25-12)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Simms

(a) RESIDENCE NO. 29 Russell St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

E

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Christopher Simms

6 DATE OF BIRTH (month, day, and year): May 1872

7 AGE: 54 Years 10 Months Days — 55 6

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Wm H. Smith

11 BIRTHPLACE OF FATHER (City or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Sarah Tibbs.

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Md.

14 Informant: Eutora Simms

(Address) 29 Russell St.

15 Filed MAR 27 1927 19

C. HAMPSON JONES, M. D.

per ..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/24 1927

17 I HEREBY CERTIFY, That I attended deceased from 3-1-, 1927, to 3-24-, 1927, that I last saw h[illegible] alive on 3-24-, 1927 and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Central Pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Hemiplegia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Herbert S Davis M. D.

, 19 (Address) 927 Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem

Date of Burial: 3/27 19

20 UNDERTAKER: Samuel A Linsley

ADDRESS: W Saratoga

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20596

## CERTIFICATE OF DEATH.

90

E 20596
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2901 Greenmount ave ST., 9-44 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leonidas D. Jeffrison

(a) RESIDENCE NO. 2901 Greenmount ave ST., ..... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, ~~Widowed~~, or ~~Divorced~~. (write the word) |
|---|---|---|
| Male | White | married |

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Edw Jeffrison

6 DATE OF BIRTH (month, day, and year) Nov 5, 1855

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 71 | 4 | 20 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) St Michaels (State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas J. Jeffrison

11 BIRTHPLACE OF FATHER (city or town) Talbot Co (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Jones

13 BIRTHPLACE OF MOTHER (city or town) Talbot Co (State or country) Maryland

14 Informant William O. Jeffrison
(Address) 53 Rasp Ave.

15 Filed MAR 27 1927 19.. E. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 1927

17 I HEREBY CERTIFY, That I attended deceased from March 2, 1927, to March 25, 1927, that I last saw him alive on March 25, 1927, and that death occurred, on the date stated above, at 9:45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar R. Sandrock M. D.

, 19 (Address) 15 W. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Lorraine Cemetery | Mar 28 1927 |
| UNDERTAKER | ADDRESS |
| John B. Spencer | 1326 N. Caroline St |

TION IS very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

200 808

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

161-001

E 20597

E 1-20597 DEATH

REGISTERED No. E 20597

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 9-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Jones

(a) RESIDENCE NO. Glyndon Md St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 3, 1927

| 7 AGE Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|
| | | 23 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) J. H. H.

(State or country)

PARENTS

10 NAME OF FATHER Robert L. Jones

11 BIRTHPLACE OF FATHER (city or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Estelle Thompson

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

Filed APR 27 1927 C. HAMPSON JONES, M. D. Registrar

For LM

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 26 1927

17

I HEREBY CERTIFY, That I attended deceased from March 3, 1927, to Mar 26, 1927, that I last saw h.. alive on March 26, 1927, and that death occurred, on the date stated above, at 12 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY —
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. K. Hoffman, M. D.

. 19 (Address) JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Luke Cemetery Glyndon Md Date of Burial March 29 27

20 UNDERTAKER Virginia A. Brooke ADDRESS 1463 E. Lacey St.

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20598

## CERTIFICATE OF DEATH.

90

E 20598

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1054 W Barre St. 21-24 WARD)

2-FULL NAME Eva Fromm

(a) RESIDENCE NO. 1054 W Barre ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William J Fromm

6 DATE OF BIRTH (month, day, and year): Oct 3 1885

7 AGE — Years: 41 | Months: 5 | Days: 22 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): (M)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Peter Wagner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Margaret Wenske

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: William J Fromm
(Address): 1054 W Barre

15 Filed MAR 27 1927 By ..... Registrar

C. HAMPSON JONES, M. D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 25 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 4, 1927, to Mar 25, 1927,

that I last saw h alive on Mar 25, 1927

and that death occurred, on the date stated above, at 5-20 m.

The CAUSE OF DEATH* was as follows:

Cardiac Decompensation

Myocardial Degeneration

(duration) ..... yrs. mos ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) ..... yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) ..... M. D.

3/26, 19 27 (Address) 4 W Mt Royal

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

DATE OF BURIAL: 3/28, 19 27

20 UNDERTAKER: George A Tuley

ADDRESS: Fulton & Fayette

Spec. –7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 20599

90 E 20599

1-PLACE OF DEATH

City of BALTIMORE: (No. 2532 Frederick St., 169 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Halter

(a) RESIDENCE NO. 2532 Frederick St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred. Life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M. | W | Married |

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Estella G. Halter

6 DATE OF BIRTH (month, day, and year) Sept 29, 1875

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min.. |
|---|---|---|---|---|
| | 52 | 5 | 26 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Candy Jobber

(b) General nature of industry, business, or establishment in which employed (or employer). 266

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Joseph Halter

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Eichelmann

13 BIRTHPLACE OF MOTHER (City or town)

(State or country) Germany

14 Informant Mrs. J. J. Halter

(Address) 2532 Frederick St

15 Filed MAR 27 1927 C. HAMPSON JONES, M. D. Registrar

Per LA

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 6, 1927 to March 25 1927

that I last saw h~~e~~ alive on March 25 1927

and that death occurred, on the date stated above, at 8. P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthenia

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 2 yrs. mos ds.

18 Where was disease contracted Home

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Harwood Kelly M. D.

3/27/27 (Address) 2027 N Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon (Catholic) Date of Burial Mar 28 19

20 UNDERTAKER Ruth Johnson ADDRESS 1804 N Broadway

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 20600

# HEALTH DEPARTMENT—CITY OF BALTIMORE.

## CERTIFICATE OF DEATH.

REGISTERED No. E 20600

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2 Cyrus Court ST. WARD 25-72 29

2-FULL NAME Frederick Lorman

(a) RESIDENCE No. Clifford Holton Lenthurst Apts 20 ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 1 - 1904

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 2 2 | 11 | 24 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lab

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Lenthurst Apts Md

PARENTS

10 NAME OF FATHER Francis Lorman Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Belgium

12 MAIDEN NAME OF MOTHER Mary E Beken

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Asbutus Md

14 Informant Francis M Lorman

(Address) Clifford Holton Lenthurst Apts

15 Filed 3 27 1927 . 19 C. HAMPTON JONES, M. D. Registrar

Dep

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 1927

17 I HEREBY CERTIFY, That I attended deceased from March 23rd, 1927, to March 25th, 1927, that I last saw h[illegible] alive on March 25th, 1927, and that death occurred, on the date stated above, at 10 15a m.

The CAUSE OF DEATH* was as follows:

Convulsion Pneumonia

Lobar Pneumonia Left Thrombosis

about 3 months ago

(duration) yrs. mos 1 Day

CONTRIBUTORY (Secondary) Epilepsy

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home (Md)

Did an operation precede death? Yes No

Date of March 23/927

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Wm H Montgomery M. D.

19 (Address) 530 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Mar. 28 1927

20 UNDERTAKER Nelson E. Stiles

ADDRESS 231 Md. Ave Westport

ATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20601

## CERTIFICATE OF DEATH.

31

REGISTERED NO. E 20601

1-PLACE OF DEATH Sinai Hospital

City of BALTIMORE: (No. ____ St., 16-68 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stella B. Moore

(a) RESIDENCE NO. 2328 Harlem Ave St. ____ Ward ____

(Usual place of abode)

Length of residence in city or town where death occurred 31 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 16 1895

7 AGE: Years 31 | Months 8 | Days 9 | IF LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Teacher 368

(b) General nature of industry, business, or establishment in which employed (or employer): Public School

(c) Name of employer: City of Baltimore

9 BIRTHPLACE (city or town): Baltimore

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Elijah J. B. Moore

11 BIRTHPLACE OF FATHER (city or town): Harford Co.

(State or country): Maryland.

12 MAIDEN NAME OF MOTHER: Lida Wilson

13 BIRTHPLACE OF MOTHER (city or town): Harford Co.

(State or country): Maryland

14 Informant: Mrs. Lida Wilson Moore

(Address): 2328 Harlem Ave

Filed ____, 19 ____ C. HAMPSON JONES, M. D.

MAR 27 1927 Per ____ Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 25 1927

17 I HEREBY CERTIFY, That I attended deceased from March 11, 1927, to March 25, 1927, that I last saw her alive on March 25, 1927 and that death occurred, on the date stated above, at 1.10 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 10 yrs. ____ mos. ____ ds (?)

CONTRIBUTORY (Secondary): Tuberculous meningitis. Cardiac failure.

(duration) ____ yrs. ____ mos. 17 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of ____

Was there an autopsy? No

What test confirmed diagnosis? Clinical tests

(Signed) Victor Levy, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Resulia Cemetery, Perryman, Md. Date of Burial: March 28 27

20 UNDERTAKER: Hughes & Jones Inc ADDRESS: 1141 N Broadway

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

281 373

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20602

1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

1 145 001

E 20602

REGISTERED NO.

27-53

City of BALTIMORE: (JOHNS HOPKINS HOSPITAL Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Margaret Taylor

(a) RESIDENCE NO. Roland Park apts. Roland Park & apts. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: John Taylor

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE: Years 37; Months; Days; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country): Illinois

PARENTS

10 NAME OF FATHER: Thomas Scanlon

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Ireland

12 MAIDEN NAME OF MOTHER: Margaret Bonglo

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Ohio

14 Informant: Records

(Address): JOHNS HOPKINS HOSPITAL

15 Filed ..... 19..... C. HAMPSON JONES, M. D. Registrar

R 27 1927 Per Eff.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 27 1927.

17 I HEREBY CERTIFY, That I attended deceased from Mar 21, 1927, to Mar 27, 1927, that I last saw her alive on Mar 27, 1927, and that death occurred, on the date stated above, at 2.10 a. m.

The CAUSE OF DEATH* was as follows: Puerperal: Intestinal obstruction following Caesarean section and myomectomy.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 3/22 - 3/26

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) J K Horner, M. D.

, 19 (Address) JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Chicago Ill — Date of Burial 3/27 1927

20 UNDERTAKER: Robert Brookerson — ADDRESS Eutaw & Hollins

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 20603

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

× 84 ✓ **E 20603**

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL St., 29 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME (Blume) Bertha Lewinsohn) Levenson

(a) RESIDENCE NO. 112 Riverside Drive, St. New York Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. 20 mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | W | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 20. 1904

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 23 | | 7 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer) Real Estate

(c) Name of employer George Piguron

9 BIRTHPLACE (city or town) Russia

(State or country) Odessa

PARENTS

10 NAME OF FATHER Joseph Lewinsohn

11 BIRTHPLACE OF FATHER (city or town) Russia

(State or country)

12 MAIDEN NAME OF MOTHER Kann

13 BIRTHPLACE OF MOTHER (city or town) Kyle Bel Russia

(State or country)

14 Informant Family records

(Address)

15 Filed JOHNS HOPKINS HOSPITAL 19 M

MAR 28 1927 C. HAMPSON JONES Registrar

by K A

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

March 27th 1927

17

I HEREBY CERTIFY, That I attended deceased from March 24th, 19 27, to March 27th, 19 27,

that I last saw h[illegible] alive on March 27th, 19 27,

and that death occurred, on the date stated above, at 10.35 P m.

The CAUSE OF DEATH* was as follows:

Brain Tumor — Glioma (benign)

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of March 25th 27

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) George E. Finney, M. D.

3/28/27 Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

John C. Mitchell March 28 1927

20 UNDERTAKER ADDRESS

New York 1900 Eutaw Place

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

**E 20604**

## CERTIFICATE OF DEATH.

74-601

**E 20604**

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH West Balto General Hospital

CITY OF BALTIMORE: (No. Raynor and Dukeland ST., 4-16 WARD)

2-FULL NAME Lottie Thornton

(a) RESIDENCE NO. 740 Redwood ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Colored | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jerry Thornton

6 DATE OF BIRTH (month, day, and year) Dec 1865

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 62 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Thornton Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Marie Entie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Jerry Thornton 740 Redwood St

15 Filed MAR 28 1927 HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/25 1927

17 I HEREBY CERTIFY, That I attended deceased from 3/24, 1927, to 3/25, 1927, that I last saw h alive on 3/25 1927 and that death occurred, on the date stated above, at 11 45 A m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Benjamin Miller, M. D.

, 19 (Address) W. B. & H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bucks. Northumberland Co Va — DATE OF BURIAL 3-28 1927

20 UNDERTAKER John N. Trader — ADDRESS 1027 Druid Hill

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20605

## CERTIFICATE OF DEATH.

12-52 129

E 20605

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 900 Hanover Cont ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Perry Wright

(a) RESIDENCE NO. 900 Hanover Cont ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Col | Widower |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of [illegible] Wright

6 DATE OF BIRTH (month, day, and year) [illegible] 1845

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or ..... min. |
|---|---|---|---|---|
| about | 82 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Deck hand

(b) General nature of industry, business, or establishment in which employed (or employer) Steam boats

(c) Name of employer Tolchester S.B. Co.

9 BIRTHPLACE (city or town) (State or country) Deals Island Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mary Emma

(Address) 900 Hanover Cont St

15 Filed ..... 19.. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 25 19 27

17 I HEREBY CERTIFY, That I attended deceased from Mar 16, 19 27 to Mar 25, 19 27.

that I last saw him alive on Mar 22, 19 27.

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) ? yrs. 2 mos. ? ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Urinary Tests

(Signed) O'Donnell M. D.

3/28, 19 27 (Address) 805 Mays St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Laurel Cem | 3-28 1927 |
| 20 UNDERTAKER John H. Toadvine | ADDRESS 1027 Round Hill |

TION is very important. See instructions on back of certificates.

E 20606 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Registered No. E 20606

1-PLACE OF DEATH

City of BALTIMORE: (No. 3434 Cedar Ave St., 13-52 ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles R West

(Residence in Baltimore: No. 3434 Cedar Ave St.; yrs. mos 20 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

| 3-SEX. | 4-COLOR OR RACE. | 5-Single, ~~Married, Widowed, or Divorced.~~ (Write the word.) |
|---|---|---|
| Male | White | |

6-DATE OF BIRTH. March 5 (Month) (Day) 1927 (Year)

7-AGE. ✓ yrs ✓ mos. 22 ds. If LESS than 1 day, ....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ✓
(b) General nature of Industry, business, or establishment in which employed (or employer) ✓ self

9-BIRTHPLACE, (State or Country). Balto Co

PARENTS.

10-NAME OF FATHER. Kennard West

11-BIRTHPLACE OF FATHER, (State or Country). Md

12-MAIDEN NAME OF MOTHER. Oda E Young

13-BIRTHPLACE OF MOTHER, (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Kennard West

(Address) 3434 Cedar Ave

15-

Filed MAR 28 1927 HAMPSON JONES, M. D. Registrar.

By [illegible]

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. March 27 1927 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobular Pneumonia

7 days

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

(Coroner)

3/27 1927 (Address) 3532 Roland Ave

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

St Marys Hampd March 28 1927

20-UNDERTAKER. ADDRESS 3611

Chenowith & Son Chestnut Ave

Spec.—12-9-25—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 20607 — 1-PLACE OF DEATH

REGISTERED NO. E 20607

City of BALTIMORE: (No. 5509 Ethelbert Ave. St., 27-55-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie A. Binnix

(a) RESIDENCE NO. 5509 Ethelbert Av St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: Wht

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Janry 29 27

7 AGE: Years — Months 2 — Days 28 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9 BIRTHPLACE (city or town): Balto
(State or country): Md.

PARENTS

10 NAME OF FATHER: John H. Binnix

11 BIRTHPLACE OF FATHER (city or town): Md
(State or country): Pa.

12 MAIDEN NAME OF MOTHER: Virginia Hoffman

13 BIRTHPLACE OF MOTHER (city or town): Balto
(State or country): Md

14 Informant: Mrs Virginia Binnix
(Address): 5509 Ethelbert Av

Filed MAR 28 1927 — HAMPSON JONES, M. D. Registrar
Per R.H.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mch 26, 27 — 19

17 I HEREBY CERTIFY, That I attended deceased from Mch. 18th, 19 27, to Mch. 26, 19 27, that I last saw h.. alive on Mch. 25, 19 27, and that death occurred, on the date stated above, at 7.20 a. m.

The CAUSE OF DEATH* was as follows: Whooping cough

(duration) .....yrs. .....mos. 2 weeks

CONTRIBUTORY (Secondary) Heart Failure spasmodic cough

(duration) .....yrs. .....mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? Visible.

(Signed) Ehrlich, M. D.

3/26 19 27 (Address) 1205 N Norfolk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. Date of Burial: March 29 27

20 UNDERTAKER: Fredk R. Cole ADDRESS: 1411 Hollins

Very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 20608

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 20608

REGISTERED NO. 1827

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hosp St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Estelle Fletcher

(a) RESIDENCE NO. 925 W Baltimore St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: Emanuel J. Fletcher

6 DATE OF BIRTH (month, day, and year): Aug 5 89

7 AGE: Years 37 Months 7 Days 21 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ohio

PARENTS

10 NAME OF FATHER: John Spencer

11 BIRTHPLACE OF FATHER (City or town) (State or country): Ohio

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ohio

14 Informant: Emanuel J. Fletcher

(Address) 925 Baltimore

15 Filed MAR 28 1927 C. HAMPSON JONES, M. D. Registrar

Pct

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3-25 1927

17 I HEREBY CERTIFY, That I attended deceased from 3/21 1927 to 3/25 1927

that I last saw her alive on 3/25 1927

and that death occurred, on the data stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Emboli

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary): Shock

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of 3/22/27

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Chas W Edwards M. D.

, 19 27 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Eldorado Ohio — Date of Burial 3/28 1927

20 UNDERTAKER: Philip Henry — ADDRESS 2016 Orleans St

Be PLAIN in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20609

CERTIFICATE OF DEATH. (Registered)

74001

E 20609

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 27 Powell Ave St. 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah A. Hands

(a) RESIDENCE NO. 27 Powell Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5/ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Wm H. Hands

6 DATE OF BIRTH (month, day, and year) Feb 12 51

7 AGE: Years 76 | Months 1 | Days 13 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) [illegible]

(State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Jane —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Mrs H. Hands

(Address) 27 Powell av

15 Filed MAR 28 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/25/27

17 I HEREBY CERTIFY, That I attended deceased from Mar 18, 1927, to Mar 25, 1927, that I last saw h~~e~~ alive on Mar 24, 1927, and that death occurred, on the date stated above, at 8 ~~A~~ P. M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) Albert Andrew J., M. D.

3/26 1927 (Address) Maplewood, Belair Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood — Date of Burial 3/28 1927

20 UNDERTAKER: Philip Henry — ADDRESS 2016 Orleans St.

Very Important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 20610

E 20610

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 229 N. Pat. Pk. Ave. St. 6-10 Ward)

2-FULL NAME John Bloss

(a) RESIDENCE NO. 229 N. Pat. Pk. Ave. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? 45 yrs. ___ mos. ___ ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna M. Bloss

6 DATE OF BIRTH (month, day, and year): Aug 3/51

7 AGE: Years 75 64 | Months 7 | Days 23 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): 015

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Germany

PARENTS

10 NAME OF FATHER John Bloss

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Ger.

12 MAIDEN NAME OF MOTHER Catherine

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Ger.

14 Informant Anna M. Bloss

(Address) 229 N. Pat. Pk. Ave

15 Filed APR 28 1927 19 C. HAMPTON JONES, M. D. Registrar

Very Important. See instructions on back of certificate.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 26/27

17 I HEREBY CERTIFY, That I attended deceased from March 19, 1927, to March 26, 1927, that I last saw him alive on March 25, 1927, and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH* was as follows:

arterio-sclerosis

arterial Hypertension.

Bronchial asthma.

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia.

(duration) ___ yrs. ___ mos. 1½ ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Exam + Sputum

(Signed) John F. Heuisler, M. D.

, 19 (Address) 722 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel — Date of Burial 3/29 1927

20 UNDERTAKER: Philip Hennig — ADDRESS 2016 Orleans St.

Spec.—1-10-21—M&T—1500 Blks.

E 20611

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

11-002

E 20611
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 503 N. Calhoun ST. 19-26 WARD)

2-FULL NAME Amos Reed

(a) RESIDENCE NO. 503 N. Calhoun ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 14. 1915

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 11 | 5 | 11 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City Md

PARENTS

10 NAME OF FATHER Preston Reed

11 BIRTHPLACE OF FATHER (city or town) (State or country) Northampton Va

12 MAIDEN NAME OF MOTHER Rebecca Satchell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Northampton Va

14 Informant Mattie Filbrans
(Address) 503 N. Calhoun St

Filed MAR 28 1927 C. HAMPSON JONES, M. D.
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 25, 1927

17 I HEREBY CERTIFY, That I attended deceased from March 8th, 1927, to March 25, 1927, that I last saw h alive on 3/25, 1927, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) A. Lee Clein, M. D.

3/25 1927 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem March 28/27

20 UNDERTAKER Daniel Carlon ADDRESS 54 ave Sta

IMPORTANT. See instructions on back of certificates.

Spec.—6-3-19—H. P. Co.—1000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20612

## CERTIFICATE OF DEATH.

31 E 20612

REGISTERED NO.

1-PLACE OF DEATH.

CITY OF BALTIMORE: (No.) 4102 Dalrymple Ave (St.) 15-15 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lizzie V. Gillaspey

(a) RESIDENCE. No. 4102 Dalrymple Ave St. WARD. Resident

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of R. Edward Gillaspey

6 DATE OF BIRTH (month, day, and year) Nov. 5, 1861

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 65 | 4 | 20 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Manchester, Md.

PARENTS

10 NAME OF FATHER George S. Krantz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Manchester, Md.

12 MAIDEN NAME OF MOTHER Magdeline Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carroll Co. Md.

14 Informant R. Edward Gillaspey (Address) 4102 Dalrymple Ave

15 Filed MAR 28 1927 C. HAMILTON JONES, M. D. Registrar Per R K

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch. 25, 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 7, 1927 to Mch. 25, 1927 that I last saw her alive on Mch. 25, 1927 and that death occurred, on the date stated above, at 6.20 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Hemorrage from Lungs

Sudden

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) Wm. M. Bamebaker M. D.

19 (Address) 2740 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL Mar 28 1927

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

109-00

**E 20613**

## CERTIFICATE OF DEATH.

**E 20613**

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3527 Edmondson ave 46-70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Barranco

(a) RESIDENCE NO. 3527 Edmondson ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 2/18. 1920

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 7 | 1 | 9. | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ——— ood

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mississippi

PARENTS

10 NAME OF FATHER Salvatore Barranco

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Rosolia Caruso

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Salvatore Barranco

(Address) 3527 Edmondson ave

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/27 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr. 25 1927 to Apr 2 1927

that I last saw h— alive on Apr 26 1927

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) 1 yrs. 0 mos ds.

CONTRIBUTORY (Secondary) Acute Heart Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) [illegible] M. D.

(Address) 943 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL 3/29 1927

20 UNDERTAKER Geo J Ruth - 1735 Harford ave

ADDRESS

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20614

## CERTIFICATE OF DEATH.

9 E 20614

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 269 N. Exeter St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sam de Pasquale

(a) RESIDENCE NO. 269 N. Exeter St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4/30-1926

| 7 AGE Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|
| | 10 | 27 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Angelo de Pasquale

11 BIRTHPLACE OF FATHER (city or town) Italy

(State or country)

12 MAIDEN NAME OF MOTHER Gaetana Agnello

13 BIRTHPLACE OF MOTHER (city or town) Italy

(State or country)

14 Informant Angelo de Pasquale

(Address) 269 N. Exeter

15 Filed MAR 28 1927 19 C. HAMPSON JONES, M. D. Registrar

By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/27 1927

17

I HEREBY CERTIFY, That I attended deceased from Mar 21 1927, to Mar 27, 1927

that I last saw h— alive on Mar 27, 1927

and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Pertussis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Stanley L. Dalrymple M. D.

Mar 28, 1927 (Address) 1058 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Vincent Cemetery

Date of Burial: 3/28 1927

20 UNDERTAKER: Geo F Ruth

ADDRESS: 1735 Hartford Ave

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20615

## CERTIFICATE OF DEATH.

1927 E 20615

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. Gen. Hosp St. 11-24 Ward)

2-FULL NAME Mary E. Raab

(a) RESIDENCE NO. Ridge Road (Fullerton Rd) St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 Color or Race: white | 5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John G. Raab

6 DATE OF BIRTH (month, day and year): Feb. 18, 1894

7 AGE: Years 33 | Months 1 | Days 6 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town): Md.

(State or country)

PARENTS

10 NAME OF FATHER: Jos. Beck

11 BIRTHPLACE OF FATHER (city or town): Md.

(State or country)

12 MAIDEN NAME OF MOTHER: Barbara Pfeiffer

13 BIRTHPLACE OF MOTHER (city or town): Md.

(State or country)

14 Informant: Mrs. Mary E. Raab

(Address) Ridge Rd Fullerton

15 Filed....., 19..... Per..... Registrar

E. HERBERT BOUNDS, M. D.

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): March 24, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia Hypostatic

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Oedema of Lungs (duration) yrs. mos. 1 ds.

(Signed) E. J. Kennedy M. D.

(Coroner)

19 27 (Address) 3 E. Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery — Date of Burial: Mar. 28 1927

20 UNDERTAKER: Frederick Lansdale Sons — ADDRESS: Fullerton

very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20616 — CERTIFICATE OF DEATH. — E 20616

REGISTERED NO. 27-55

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST. WARD)

2-FULL NAME Lewis Hurley

(a) RESIDENCE NO. 211 W. Hayward Avenue ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 28, 1907

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 19 | 3 2 | 29 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brick layer Apt

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer Syd Schaeffer Baltimore Md

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Harry M Hurley

11 BIRTHPLACE OF FATHER (city or town) (State or country) " " Md

12 MAIDEN NAME OF MOTHER Margaret M Knight

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Margaret Hurley

(Address) 211 W. Hayward Ave

15 Filed 1927 Per Registrar

C. HAMPSON JONES, M. D.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-27 1927

17

I HEREBY CERTIFY, That I attended deceased from 3-24, 1927, to 3-27, 1927,

that I last saw him alive on 3-27, 1927,

and that death occurred, on the date stated above, at 12 50 m.

The CAUSE OF DEATH* was as follows:

Acute appendicitis + peritonitis

(duration) yrs. mos 3 ds

CONTRIBUTORY (Secondary) Tuberculosis pulmonum

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3-24-27

Was there an autopsy? No

What test confirmed diagnosis? Operation findings.

(Signed) Lopez Cuba, M. D.

, 19 (Address) 1 Cager Doctors

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet — DATE OF BURIAL Mar 31 1927

20 UNDERTAKER W M Cook — ADDRESS 522 Aisquith

MAR 28 1927

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

128 E 20617

E 20617

## CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 4018 Mass. ave. Brighton Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Caroline H. Finsley

(a) RESIDENCE NO. 4018 Mass. ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 29th 1862

7 AGE: Years 64 Months 7 Days 24 IF LESS than 1 day.....brs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Va

(State or country)

PARENTS

10 NAME OF FATHER Wm E. Wrysham

11 BIRTHPLACE OF FATHER (city or town) Va

(State or country)

12 MAIDEN NAME OF MOTHER Mary E. Williamson

13 BIRTHPLACE OF MOTHER (city or town) Va

(State or country)

14 Informant D'Arcy M. Finsley

(Address) 4018 Mass ave

15 Filed MAR 28 1927 19

Per

HARRISON JONES, M. D.

Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25th 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) mos. ds.

(Signed) Thos. E. Horton M. D.

(Coroner)

March 28th 1927 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Date of Burial: Mar 28 1927

20 UNDERTAKER: J. M. Cook ADDRESS 507 E. Fort Ave

Very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20618

## CERTIFICATE OF DEATH.

129

E 20618

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 509 South East Avenue 26 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John J. Nigl

(Residence in Baltimore: No. 509 South East Avenue St.; 48 yrs., 7 mos. 7 ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, July (Month) 19 (Day), 1878 (Year)

7-AGE, 48 yrs. 7 8 mos. 7 ds. If LESS than 1 day, ....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Plumber
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Andrew Nigl

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Catherine Gebhardt

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Nigl

(Address) 509 S. East Ave.

15-

Filed R 28 1927, 191

C. HAMPSON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 26 (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb. 9 1927, to March 26 1927, that I saw him alive on March 26 1927, and that death occurred, on the date stated above, at 4-45 p. m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

To my knowledge (Duration) yrs. 1 mos. 17 ds.

CONTRIBUTORY (Secondary) Chronic Parenchymatous Nephritis

To my knowledge (Duration) mos. 17 ds.

(Signed) Frances A. Carpenter M. D.

Mar 26, 1927. (Address) 2101 Madison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oaklawn Cemetery

DATE OF BURIAL, March 29 1927

20-UNDERTAKER Jirkler & Jirkler

ADDRESS 1739 E Eager St.

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20619

## CERTIFICATE OF DEATH.

15-22 31 E 20619

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1812 Laurens ST. (WARD)

2-FULL NAME Lulu Belle Garbrough

(a) RESIDENCE NO. 1812 Laurens ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 5- 1909

7 AGE: Years 18 Months 0 Days 19 If LESS than 1 day, ..... hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Reuben Garbrough

11 BIRTHPLACE OF FATHER (city or town) (State or country) D. C.

12 MAIDEN NAME OF MOTHER Bessie Hill

13 BIRTHPLACE OF MOTHER (city or town) Goldsboro (State or country) N. C.

14 Informant Reuben Garbrough

(Address) 1812 Laurens

15 Filed MAR 28 1927 C. HAMPSON JONES, M. D. Registrar

Per R. H.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 24th 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar. 23rd 1927, to Mar. 24th 1927.

that I last saw h alive on Mar. 24th 1927

and that death occurred, on the date stated above, at 11.50 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) — yrs. — mos — ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Jas Taylor Bell M. D.

19 (Address) 713 Gilmor

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: Mar. 28 1927

20 UNDERTAKER: Mrs. R. G. Elliott — ADDRESS: 172 Carlton Ave.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 20620

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

13-90 E 20620

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 3630. Sycamore Avenue. St., ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma A. Williams.

(a) Residence No. 3630. Sycamore Avenue. St., ..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

| 3-SEX | 4-COLOR OR RACE, | 5-Single, Married, Widowed, or Divorced. (Write the word.) |
|---|---|---|
| female. | white. | married. |

5a-If married, widowed, or divorced, ~~XXXXXXXXXX~~ WIFE of Frank E. Williams.

6-DATE OF BIRTH (month, day and year) June, 11/1860

7-AGE. 66. yrs. 9. mos. 16. ds. If LESS than 1 day, ....hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... house wife.

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Baltimore.
(State or Country), Maryland.

PARENTS

10-NAME OF FATHER, Unknown.

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Unknown.

12-MAIDEN NAME OF MOTHER, Susan Niles.

13-BIRTHPLACE OF MOTHER (city or town) Baltimore. (State or Country), Maryland.

14- (Informant) Frank E. Williams (husband)
(Address) 3630. Sycamore, Avenue.

15- Filed MAR 28 1927 C. HAMPSON JONES, M. D. Registrar.
Per .....

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3-27-1927

17- I HEREBY CERTIFY, That I attended deceased from Nov 15 1926 to March 26 1927.

that I last saw h[illegible] alive on March 26 1927.

and that death occurred, on the date stated above, at 5.27 p. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Chronic Hypertension

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) A. J. Dauer M. D.

3-27-, 1927 (Address) 600 N. 33 st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19-PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL. |
|---|---|
| St. Marys cem (Hampden) | March, 29/1927. |
| 20-UNDERTAKER. | ADDRESS |
| J. Walter Davis. | 3307. Paine St. |

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20621

## CERTIFICATE OF DEATH.

162

E 20621

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 15-58 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Chomet

(a) RESIDENCE NO. 3714 Towanda Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): 3-27-27

| 7 AGE | Years | Months | Days | IF LESS than 1 day... hrs. or.....min. |
|---|---|---|---|---|
| | | | | ½ |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ...

(b) General nature of industry, business, or establishment in which employed (or employer): ...

(c) Name of employer: ...

9 BIRTHPLACE (city or town): ...

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Reuben Chomet

11 BIRTHPLACE OF FATHER (city or town): ...

(State or country) N.Y.C.

12 MAIDEN NAME OF MOTHER Anna Waserman

13 BIRTHPLACE OF MOTHER (city or town): ...

(State or country) N.Y.C.

14 Informant: Hosp. Record

(Address)

15 Filed MAR 28 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: 3-27-27.

17

I HEREBY CERTIFY, That I attended deceased from 3-27, 1927, to 3-27, 1927

that I last saw him alive on 3-27, 1927,

and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH* was as follows:

Asphyxia

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted

If not at place of death? ...

Did an operation precede death? ...Date of...

Was there an autopsy? No

What test confirmed diagnosis? Clinical tests

(Signed) Henry Weinstein, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rascdale — Date of Burial 3/28 1927

20 UNDERTAKER: Jack Levin — ADDRESS 1434 E Eager St

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 20622

114

E 20622

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of BALTIMORE: (No. Sinai Hospital St. 64 Ward)

2-FULL NAME Isaac Flax

(a) RESIDENCE NO. 125 N. Broadway St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Esther Flax

6 DATE OF BIRTH (month, day, and year): unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 49 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Printer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country) Russia

PARENTS

10 NAME OF FATHER Charles Flax

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Russia

12 MAIDEN NAME OF MOTHER B Myers

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Russia

14 Informant: Esther Flax

(Address) 125 N. Broadway

15 Filed MAR 28 1927, 19 C. HAMDEN JOURS M. Registrar

Pay

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 27/27 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Probably Gastro-intestinal Toxemia (undetermined) (duration) yrs mos. 5 ds.

(Signed) C. H. Mullen M. D.

(Coroner)

3/28/27 19 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Hebrew Rom

Date of Burial: 3/28/27 19

20 UNDERTAKER: Jack Lewis

ADDRESS 1439 E Baltimore

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20623

161-001

E 20623

## CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 3479 E. Lombard St. 70-2 Ward)

2-FULL NAME Doris May Keller.

(a) RESIDENCE NO. 3479 E. Lombard St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 13-1927

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | | 1 | 14 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER Charles W. Keller

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ohio

12 MAIDEN NAME OF MOTHER May Knight

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) W. Va.

14 Informant May Keller (Mother)

(Address) 3479 E. Lombard St.

15 Filed MAR 28 1927 C. HAMPSON JONES, M. D. Registrar

Per [illegible]

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27-1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 13, 1927, to Mar 27, 1927, that I last saw h... alive on Mar 27, 1927, and that death occurred, on the date stated above, at 6.50 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Septicaemia

(duration) ...yrs. ...mos. 2 ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. C. Campbell, M. D.

Mar 28 1927 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Schwartz Cem. March 28 1927

20 UNDERTAKER — ADDRESS

Lilly & Zeiler 403 S. Wolfe St.

Spec.—12-9-25—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20624

## CERTIFICATE OF DEATH.

90 E 20624

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 523 N. Streeper St. 6-11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pauline A. Bahn

(a) RESIDENCE NO. 523 N Streeper St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 6-1849

| 7 AGE Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|
| 77 78 | 5 | 19. | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER August Bahn

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Johanna Bamm

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Elizabeth H. Bell

(Address) 523 N. Streeper St

15 Filed MAR 28 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 19 27

17

I HEREBY CERTIFY, That I attended deceased from 3-19, 19 27, to 3-25, 19 27, that I last saw h[illegible] alive on 3-24, 19 27, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. Frame, M. D.

, 19 (Address) 2929 W. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Baltimore Cemetery | Mar 28 1927 |
| UNDERTAKER | ADDRESS |
| Wm C Miller & Son | 2334 Jeffers 38 |

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20625

## CERTIFICATE OF DEATH.

49 ✓ E 20625

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2823 Frederick Ave ST. 20-69 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Richard Anthony

(a) RESIDENCE NO. 2823 Frederick Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single. |

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 27/1907

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 19 | 11 | 27 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Anthony

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Margaret J Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant John Anthony (Address) 2823 Frederick Ave

15 Filed MAR 28 1927 19 C. HAMPSON JONES, M. D. Registrar Per

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 26 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 1 .1927. to Mar 25 .1927

that I last saw him alive on Mar 25 .1927

and that death occurred, on the date stated above, at 6 20 A.m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Femur

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Metastasis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Glassman, M. D.

Mar 28 1927 (Address) 2687 Druid Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL Mar 30 1927

20 UNDERTAKER Harry A. Asmus — ADDRESS 4204 Ridgewood Ave

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

129

E 20626

## CERTIFICATE OF DEATH.

REGISTERED NO. E 20628

1-PLACE OF DEATH

City of BALTIMORE: (No. 930 Linden Ave St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John E. Anderson

(a) RESIDENCE NO. 930 Linden Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice Anderson

6 DATE OF BIRTH (month, day, and year) 1876

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 57 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

PARENTS

9 BIRTHPLACE (City or town) Edgewater

(State or country) Va

10 NAME OF FATHER John E Anderson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Mary Fitzhugh

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Alice Anderson

(Address) 930 Linden Ave

15 Filed ....., 19.. C. HAMPSON JONES, M. D. Registrar

MAR 28 1927 Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 12 1926, to March 25, 1927, that I last saw him alive on March 23 1927, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Chronic Pancreatitis. Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinalysis

(Signed) H. S. McCard M. D.

3/28 1927 (Address) 2005 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cem Date of Burial 3/28 1927

UNDERTAKER Samuel P Straughey ADDRESS Westfield

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20627

## CERTIFICATE OF DEATH.

129

E 20627

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 1014 S. Futaw St. St. 21-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Seaton.(C)

(a) RESIDENCE NO. 1014 S. Futaw St. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male. | Colored | Married |

5a If married, widowed or divorced HUSBAND of (or WIFE of) Susie Seaton.(C)

6 DATE OF BIRTH (month, day, and year) December 8, 1893

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 33 | 3 | 20 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia.

PARENTS

10 NAME OF FATHER George Seaton.(C)

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia.

12 MAIDEN NAME OF MOTHER Louisa Washington (C)

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia.

14 Informant Louisa Seaton.(C) mother.

(Address) 110 N. Madeira St.

15 Filed_____, 19 C. HAMPSON JONES, M. D. Registrar

By:

AUG 28 1927

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Thos. Kernan M. D. (Coroner)

8/27, 19 27 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Lawn Date of Burial 3/28 19 27

20 UNDERTAKER Edmund Regan DIRECTION 1631 E. Eager

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 20628

REGISTERED NO. E 20628

1-PLACE OF DEATH

City of BALTIMORE: (No. 646 Portland St. 22-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward J Day

(a) RESIDENCE NO. 646 Portland St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eva E Day.

6 DATE OF BIRTH (month, day, and year) Dec 18 1853

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 73 | 3 | 7 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (City or town) Not Known

(State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known

(State or country)

14 Informant Eva E Day

(Address) 646 Portland St

15 Filed ..... 19 .....

C. HAMPSON JONES, M. D. Registrar

MAR 30 1927 P.M.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-25 1927

17 I HEREBY CERTIFY, That I attended deceased from March 9th, 1927, to March 25th, 1927,

that I last saw him alive on March 26th, 1927,

and that death occurred, on the date stated above, at 6.50 P. m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) myocarditis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H Poulton M. D.

3/26, 1927 (Address) 3904 Hanson Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL 1118 Olivet

Date of Burial 3-28 1927

20 UNDERTAKER Earle Hardware

ADDRESS

Key: Important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 20629

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 20629

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Baltimore General Hosp (ST.) (WARD)

2-FULL NAME Mr. Paul S Sitzman

(a) RESIDENCE NO. Woodlawn Md ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct-25-1908

7 AGE: Years 18 Months 5 Days 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): Hardware Store

(c) Name of employer N. G. Dewalt

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Maurice Sitzman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Ethel Hooker 3/27 1977

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mrs Baltimore Jr, Box Road. (Address)

15 Filed MAR 28 1927 C. HAMPSON JONES Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/27/27

17 I HEREBY CERTIFY, That I attended deceased from 3/24, 1977, to 3/27, 1927, that I last saw h[illegible] alive on 3/27, 1927, and that death occurred, on the date stated above, at 8:30 p. m.

The CAUSE OF DEATH* was as follows:

(a) Chronic Ulcerative colitis

(b) Abscess of pelvic connective tissue

(c) Pneumonia

CONTRIBUTORY (Secondary): (duration) yrs. 2 mos. 7 ds.

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 3/24/27

Was there an autopsy? yes.

What test confirmed diagnosis? Gen'l Path-autopsy

(Signed) Charles L Jones, M. D.

Address Balt. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem

DATE OF BURIAL: Mar 30 1927

20 UNDERTAKER: Geo B Cook

ADDRESS: 1003 N. Gate

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20630

## CERTIFICATE OF DEATH.

E 20630
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1403 N. Fremont St. Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Christina Bennett

(a) RESIDENCE NO. 1403 N. Fremont St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | Col | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown 1893

6 DATE OF BIRTH (month, day, and year)

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 34 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Dudley Lindsay

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Alice Bland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant John Lindsay
(Address) 1403 Fremont St.

15 Filed APR 28 1927 19 C. HAMILTON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) yrs. mos. 25 ds.

CONTRIBUTORY (Secondary) no other history

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.
(Coroner)

March 28 1927 (Address) 280 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Petersburg Va Date of Burial March 29 1927

20 UNDERTAKER Chas. H. Chase Son ADDRESS 1400 Maker

Spec.—1-10-21—M&T—1500 Bks.

20631

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

113 E 20631

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1631 Baker ST. 15-21 WARD)

2-FULL NAME Martha P. Graves

(a) RESIDENCE NO. 1631 Baker ST. ... WARD ...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov. 2 - 26

7 AGE — Years: — Months: 4 — Days: 25 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Otis Graves

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Creamer Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Creamer Graves

(Address): 1631 Baker St

15 Filed: MAR 28 1927 Entd: RR

H. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 27 19 27

17 I HEREBY CERTIFY, That I attended deceased from March 26, 1927, to March 27, 1927, that I last saw her alive on March 27, 1927, and that death occurred, on the date stated above, 6 a m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) P. H. Hatcher M. D.

March 28 1927 (Address) 1258 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion — DATE OF BURIAL: March 28 1927

20 UNDERTAKER: James H. Chase — ADDRESS: 1400 Madison

Spec.—1-10-21—M&T—1500 Bks.

# E 20632 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

16 5001

E 20632
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) 1418 E Preston ST. 9-17 (WARD)

2-FULL NAME Richard Edw Fisher

(a) RESIDENCE NO. 1418 E Preston ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3-27-27.

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Geo. E. Fisher

11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)

12 MAIDEN NAME OF MOTHER Maggie E. Spurry

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant Geo. E. Fisher
(Address) 1418 E Preston st

15 Filed MAR 28 1927, 19 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 27 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 27, 1927, to Mar 27, 1927, that I last saw h[illegible] alive on Mar 27, 1927, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Premature birth —
about 6 months —

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter W White Jr. M.D.

3/28 1927 (Address) 2800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fork. Balto Co. | DATE OF BURIAL Mar 28 1927

20 UNDERTAKER Robt J Turner | ADDRESS 1 & 2 N. Gay

Spec.—12-9-25—A Co.—200 Bks.

20633

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 E 20633

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St., (or) 26-37 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Miller

(a) RESIDENCE NO. Baltimore City Hospitals St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Widower |

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE~~ of) Elizabeth C. Miller

6 DATE OF BIRTH (month, day, and year) 1855 Unknown.

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 72 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bartender

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Lawrence Miller

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed MAR 28 1927 C. HAMPDEN JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from March 25 19 27 to March 26 19 27, that I last saw him alive on March 26 19 27, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-Ray

(Signed) W. C. Fallin M. D.

3-26 1927 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — Date of Burial 3/29/1927

20 UNDERTAKER John F. Cowan & Son — ADDRESS 901 Hollins St

per F. F. Cowan

Spec.—1-10-21—M&T—1500 Bks.

20634

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

44 E 20634

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 901 Beaumont ave ST. 27-48 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edwin Schaffer

(a) RESIDENCE NO. 901 Beaumont ST. Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elva K Schaeffer

6 DATE OF BIRTH (month, day, and year) Dec 15 63

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 63 | 3 | 11 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll Co Md.

PARENTS

10 NAME OF FATHER Jacob Schaffer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Hoffacker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Elva Schaeffer

(Address) 901 Beaumont Ave

15 Filed MAR 28 1927 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 22. 1927 to March 26 1927

that I last saw h alive on March 25 1927

and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Infection of Gall Bladder

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John F Crain M. D.

19 (Address) 612 W 40th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Luther Miller Memorial Cemetery Gouldsboro Pa

DATE OF BURIAL March 29 1927

20 UNDERTAKER W M Routson

ADDRESS 2228 W North St

C. HAMPSON JONES, M. D.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20635

## CERTIFICATE OF DEATH.

X 44 E 20635

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSP. St. 759 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice C. O'Brien (Alice C. O'Brien)

(a) RESIDENCE NO. Vicksburg Miss St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. 19 ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, (Widowed) or Divorced, (write the word) |
|---|---|---|
| F | W | widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John O'Brien

6 DATE OF BIRTH (month, day, and year) October 1871

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 55 | 5 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: h. w.

(b) General nature of industry, business, or establishment in which employed (or employer): home

(c) Name of employer: none

9 BIRTHPLACE (city or town) Vicksburg

(State or country) Miss.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) ?

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Records—

(Address) JOHNS HOPKINS HOSP.

15 Filed_____ 19____ Registrar

By _____

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

March 27 1927

17

I HEREBY CERTIFY, That I attended deceased from March 8 1927, to March 27, 1927, that I last saw h. alive on March 27, 1927, and that death occurred, on the date stated above, at 9 p. m.

The CAUSE OF DEATH* was as follows:

carcinoma of liver

myocardial failure

(duration) ___ yrs. 3 mos. ___ ds.

CONTRIBUTORY (Secondary) myocardial failure

(duration) ___ yrs. ___ mos. 7 ds.

18 Where was disease contracted if not at place of death? Vicksburg Miss

Did an operation precede death? yes Date of March 14

Was there an autopsy? ✓

What test confirmed diagnosis? exploration of abdomen

(Signed) Edward Kelly, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Vicksburg, Miss. Date of Burial Mar. 28, 1927

20 UNDERTAKER John B. Mitchell ADDRESS 1900 Eutaw Pl.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20636

## CERTIFICATE OF DEATH.

100-001

E 20636

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1923 Division St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carmen Ball

(a) RESIDENCE NO. 1923 Division St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Left yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec 3 1926

7 AGE: Years — Months: 3 — Days: 23 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md

PARENTS

10 NAME OF FATHER: Earl Ball

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Md

12 MAIDEN NAME OF MOTHER: Carmen Coombs

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Md

14 Informant: Mrs. Carmen Coombs

(Address) 1923 Division St

Filed March 28 1927 H. HAMPSON JONES, M. D.

Per Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 26, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) no other history

(duration) yrs. mos. ds.

(Signed) J. J. Kennedy M. D.

(Coroner)

March 26, 1927 (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

(Where was disease contracted, if not at place of death?)

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Date of Burial: March 28 1927

20 UNDERTAKER: George T. A. Gibson ADDRESS: 1735 Druid Hill Ave

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20637

## CERTIFICATE OF DEATH.

1 81 00 1

E 20637

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 3002 Stafford St. 20-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John G. Wolf

(a) RESIDENCE NO. 3002 Stafford St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Widower |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 15th 1865

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| 62 | 61 | 1 | 10 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gardener

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Robt Garrett

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant John H. Wolff

(Address) 3002 Stafford St

Filed MAR 28 1927 19 C. HAMPSON JONES, M. D.

Per Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25th 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Asphyxiation by Illuminating Gas

Retired at 10 P.M. found dead 6 A.M.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Thos. B. Horkan M. D.

(Coroner)

March 27 1927 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. Date of Burial Mar 29 1927.

20 UNDERTAKER Chas. W. Dill ADDRESS 3109 Frederick Ave

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20638 101-001 E 20638

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospitals Ward) 6-10

2-FULL NAME Henry Roth -

(a) RESIDENCE NO. 176 ~~1011~~ Hare St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Francis Roth.

6 DATE OF BIRTH (month, day, and year) Aug. ?.

| 7 AGE Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|
| 72 | 7 | | |

8 OCCUPATION OF DECEASED ~~Meat Carrier~~ Butcher.

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) 013

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Adam Roth -

11 BIRTHPLACE OF FATHER (city or town) .....

(State or country) Germany -

12 MAIDEN NAME OF MOTHER Elizabeth

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) Germany -

14 Informant Francis Roth

(Address) 141 N Hare St

15 Filed ..... 19 ..... Registrar

MAR 28 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 March 26.

17 I HEREBY CERTIFY, That I attended deceased from Dec. 14 1926 to March. 26, 1927, that I last saw him alive on March 26, 1927, and that death occurred, on the date stated above, at 12.45 P m.

The CAUSE OF DEATH* was as follows: Generalized Arteriosclerosis, Hypertension Myocarditis - Benign Prostatic Hypertrophy and Chronic Nephritis

(duration) Chronic ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia Left

(duration) ..... yrs. ..... mos. 2 wks.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Feb. 10, 1927

Was there an autopsy? No

What test confirmed diagnosis? Surgical Specimen & Operation

(Signed) E. Bayer M. D.

, 19 (Address) Balto City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem. — Date of Burial: Mar 29 1927

20 UNDERTAKER: John Ulrich — ADDRESS: 2008 Eden

C. HAMPSON REGISTRAR

Spec.—12-9-25—A Co.—200 Bks.

John McGhee Barron

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20639

## CERTIFICATE OF DEATH.

106-001

E 20639

REGISTERED NO.

1-PLACE OF DEATH South Balt. Hospital

City of BALTIMORE: (No. 1135 Light St. (Ward) 7746

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME John McGhee Barron

(a) RESIDENCE NO. 5606 York Rd. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 19 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Swift Envelope Co

9 BIRTHPLACE (city or town)

(State or country) Penna.

PARENTS

10 NAME OF FATHER John M Barron

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Penna

12 MAIDEN NAME OF MOTHER Jane V Smith

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Penna

14 Informant John M Barron Jr.

(Address) 5606 York road

15 Filed ..... 19 C. HAMPTON JONES, M. D.

Registrar

MAR 26 1927 Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26, 1927

17

I HEREBY CERTIFY, That I attended deceased from March 23, 1927, to March 26, 1927, that I last saw h[illegible] alive on March 26, 1927, and that death occurred, on the date stated above, at 2:00 P. m.

The CAUSE OF DEATH* was as follows:

Streptococcus Septicemia

Broncho pneumonia

Endocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 3 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) B. S. Muller, M. D.

, 19 (Address) South Balt. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. Date of Burial March 30 1927

20 UNDERTAKER Dr. John Ullrick ADDRESS 2008 Orleans

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20640

CERTIFICATE OF DEATH.

188-002

E 20640

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital, St. 4-7 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rozier Furr.(C)

(a) RESIDENCE NO. Do not know. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male. | Colored | Single. |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -------

6 DATE OF BIRTH (month, day, and year) Do not know.

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 24 | --------- | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Hilsborough, Va.

PARENTS

10 NAME OF FATHER Forrest Furr.(C)

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia.

12 MAIDEN NAME OF MOTHER Ella Jackson.(C)

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia.

14 Informant (Address) James A. Furr.(C) Brother. 422 Oakdale St. N. W. Washington, D. C.

15 1927 C. HAMPSON JONES, M. D. Registrar

Pa. 204 MORGUE

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull.
Struck by a street car while crossing track.. Accidental Death.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Leinhardt M. D. (Coroner)

8/24 19 27 (Address) 1017 E. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death? Curtis Bve. Curtis Bay. March 12, 1927

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 1927 19

20 UNDERTAKER ADDRESS

Commissioner Health.

UNIVERSITY OF MARYLAND MAR 28

Spec.-7-17-26—A Co.—200 Bks.

E 20641

# HEALTH DEPARTMENT—CITY OF BALTIMORE

43 E 20641

## CERTIFICATE OF DEATH

REGISTERED NO. 12-30

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel M. Jeffers

(a) RESIDENCE NO. 106 W. Conway St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. da. How long in U. S. if of foreign birth? yrs. mos. da.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Wh.

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE: Years 65 Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Collector

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant S. M. Jeffers

(Address) 432 Wheeler Ave

15 Filed 8 1927 C. HAMPSON JONES, M. D. Registrar

Per RFA

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 March 27 - 1927

17 I HEREBY CERTIFY, That I attended deceased from March 22, 19 27, to March 27, 19 27,

that I last saw h alive on 3/27/27, 19 27

and that death occurred, on the date stated above, at 4.40 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Tongue

Generalized Arterio-sclerosis

2

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Cerebral hemorrhage Pneumonia

(duration) yrs. mos. 2 da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Jacob Rosenau M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

Date of Burial: 3/31 1927

20 UNDERTAKER: Robert Brookerson

ADDRESS: Catonsville Baltimore Co

Cor—1-12-23—M&T—100 Bks.

E 20642 HEALTH DEPARTMENT—CITY OF BALTIMORE E 20642

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) City Hospital (ST.) 10-37 (WARD) 197

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herbert J. Holtin

(a) RESIDENCE NO. Cambridge Mass ST., WARD

(Usual place of abode) Unknown

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| M | W | M. |

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Daisy Holtin

6 DATE OF BIRTH (month, day, and year) Nov 14 1901

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 25 | 4 | 10 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Cambridge (State or country) Mass

10 NAME OF FATHER Joseph H. Holtin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mass

12 MAIDEN NAME OF MOTHER Ida Racine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wisconsin

Informant Winfred J. Holtin

(Address) 91 Montgomery St. Cambridge Mass

Filed 8 1927 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun shot wound of Chest Homicide Self Defense

(duration) yrs. mos. 2 Sec

CONTRIBUTORY (Secondary) Shock

(duration) yrs. mos. 2 hrs

(Signed) G C Yates, M. D.

May 24 1927 (Address) 143 Main Bray.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cambridge Mass DATE OF BURIAL Mar 28 1927

20 UNDERTAKER John F. Denny ADDRESS 715 Eight St

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 206[illegible] 90 E 20643

## CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1808 N Gay ST. 8-16 WARD)

2-FULL NAME Georgeia E Insco

(a) RESIDENCE NO. 1808 N Gay st ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph B Insco

6 DATE OF BIRTH (month, day, and year) June 16 1849

| 7 AGE Years | Months | Days | If LESS than 1 day, ....hrs or ....min. |
|---|---|---|---|
| 77 | 9 | 10 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) Harford Co (State or country) Md

PARENTS

10 NAME OF FATHER Richard Gallion

11 BIRTHPLACE OF FATHER (city or town) Harford Co (State or country) Md

12 MAIDEN NAME OF MOTHER Lucy Middleditch

13 BIRTHPLACE OF MOTHER (city or town) Harford Co (State or country) Md

14 Informant James F Gallion
(Address) 104 E Cross St

15 Filed 8 1927 C. HAMPSON JONES, M. D. Registrar
Pat

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26 1927

17 I HEREBY CERTIFY, That I attended deceased from March 12, 1927, to March 26, 1927, that I last saw her alive on March 26, 1927, and that death occurred, on the date stated above, at 4:40 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis.

(duration) several yrs. mos ds.

CONTRIBUTORY (Secondary) senile Debility.

(duration) years yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) D H Buxton, M. D.

3/27, 1927 (Address) 301 E Cross St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet — DATE OF BURIAL Mar 29 1927

20 UNDERTAKER John F Denny — ADDRESS 715 Light St

Spec.—1-12-23—M&T—500 Bks.

20644

# HEALTH DEPARTMENT—CITY OF BALTIMORE

20644

## CERTIFICATE OF DEATH.

101-01

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2113 Homewood Ave (St.) (Ward) 46

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles A Edberg

(a) RESIDENCE NO. 2113 Homewood Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Edberg

6 DATE OF BIRTH (month, day, and year) Aug 30 - 1862

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min |
|---|---|---|---|---|
| | 64 | 6 | 24 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Elizabeth Edberg

(Address) 2113 Homewood Ave

15 Filed 1927 19 G. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 26 1927

17 I HEREBY CERTIFY, That I attended deceased from Mch 24, 1927, to Mch 26, 1927, that I last saw h[illegible] alive on Mch 26, 1927, and that death occurred, on the date stated above, at 3:10 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Myocarditis Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical Signs

(Signed) W. H. Hagan M. D.

3/28, 1927 (Address) 1429 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Mar 29 1927

20 UNDERTAKER W. J. Schmelz & Sons

ADDRESS North Ave

Spec.-7-17-26—A Co.—200 Bks.

E 20645

HEALTH DEPARTMENT— F BALTIMORE

90

E 20645

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1711 W. Lanvale St., 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Melvina R. Eward

(a) RESIDENCE NO. 1711 W. Lanvale St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 86 yrs. 7 mos. 1 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John N. Eward.

6 DATE OF BIRTH (month, day, and year): Aug. 25 1840

7 AGE: Years 86 Months 7 Days 1 IF LESS than 1 day ____ hrs. or ____ min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md.

PARENTS

10 NAME OF FATHER: Wesley Hartlove

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Md

12 MAIDEN NAME OF MOTHER: Elizabeth Jory

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md

14 Informant: Mr. Thomas F. Hartlove

(Address): 4014 Hawthorne Ave.

15 Filed: 3 1927 Per

C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar. 26 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar. 1, 1927, to Mar 26, 1927, that I last saw h[illegible] alive on Mar 26, 1927, and that death occurred, on the data stated above, at 10.25 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insuff.

(duration) 4 yrs. mos. da.

CONTRIBUTORY (Secondary): Acute dilatation

(duration) yrs. mos. 1 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Data of

Was there an autopsy? No

What test confirmed diagnosis? P.E.

(Signed) Dimon C. Todd M. D.

3/28. 1927 (Address) 735 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cem. Date of Burial: Mar. 29 1927

20 UNDERTAKER: Wm Tucker Sons. ADDRESS: North & Pa

Spec.–7-17-26–A Co.—200 Bks.

E 20646

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

38 E 20646

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. 22-33 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Lockney

(a) RESIDENCE NO. 114 E. Montgomery St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | White | Widower |

5a If ~~married, widowed, or divorced~~ HUSBAND ~~of~~ (or) WIFE ~~of~~ Mary Lockney

6 DATE OF BIRTH (month, day, and year) — — 1869

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|---|
| 58 | 57 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cattle dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) England

PARENTS

10 NAME OF FATHER John Lockney

11 BIRTHPLACE OF FATHER (City or town)

(State or country) England

12 MAIDEN NAME OF MOTHER Mary Dougherty

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) England

14 Informant Mary Lockney

(Address) 114 E. Montgomery

15 Filed 1927 C. HAMPSON JONES, M.D.

Per ARH Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-26 1927

17 I HEREBY CERTIFY, That I attended deceased from 3-22, 1927, to 3-26, 1927, that I last saw him alive on 3-26, 1927, and that death occurred, on the date stated above, at 10 26 P m.

The CAUSE OF DEATH* was as follows:

Syphilitic Cardiovascular disease

Cerebral Thrombosis

Hemiplegia

(duration) 13 yrs. mos. ds.

CONTRIBUTORY (Secondary) Terminal Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At work

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) E K Mueller M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Date of Burial 9 1927

20 UNDERTAKER J. J. Lahey & Sons ADDRESS 1518 Eutaw St

Spec.—1-10-21—M&T—1500 Bks.

E 20647

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20647

## CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5111 Wilson Ave ST., 27-56 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie E. Cox

(a) RESIDENCE No. 5111 Wilson Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced
~~(b) HUSBAND~~ of
(or) WIFE of Melchoir Cox

6 DATE OF BIRTH (month, day, and year) Nov 17 1855

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 71 | 4 | 11 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Hampstead
(State or country) Maryland

PARENTS

10 NAME OF FATHER Robert H Reese

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Rebecca McCauley

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Clarence Rote
(Address) 5111 Wilson Ave

15 MAR 1927 C. HAMPSON JONES, M. D. Registrar
Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-28- 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 2, 1927, to Mar 28- 1927, that I last saw her alive on March 27, 1927, and that death occurred, on the date stated above, at 7.40 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? None

(Signed) C. H. Hardesty, M. D.

3-29, 1927 (Address) 1 E. Fayette Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hampstead Md — DATE OF BURIAL 3-30 1927

20 UNDERTAKER Edw. C. Tipton, Hampstead Md — ADDRESS

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

X/31 E 20648

~~E 20648~~ 945

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSP. St., 7-9 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME John Roberts

(a) RESIDENCE NO. 236 Lincoln St St. Thomasville Pa

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | married |

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1875

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 52 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer & Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

9 BIRTHPLACE (city or town) Wales

(State or country)

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) Wales

(State or country)

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) Wales

(State or country)

14 Informant Beards —

(Address) JOHNS HOPKINS HOSP.

15 Filed 1927 C. HAMPSON JONES, M. D.

Per Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 28 1927

17

I HEREBY CERTIFY, That I attended deceased from Mar 8, 1927, to Mar. 28, 1927, that I last saw h. alive on Mar. 28, 1927, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Pyelonephritis, septicaemia

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? yes Date of 3/11-17/27

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) H B Smith M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Palmstown Pa Date of Burial 3/28/27

20 UNDERTAKER Joseph Ahrens ADDRESS 221 Bway

Cor.—12-9-25—A Co.—200 Bks.

E 20649

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20649

## CERTIFICATE OF DEATH.

REGISTERED NO. 90 2332

1-PLACE OF DEATH B.M.D R.R.Co.office.

City of BALTIMORE: (No. Light & Donaldson Sts. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Elsworth Hiller.

(a) RESIDENCE NO. 2119 Hanover St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. 10 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male. | White. | Single. |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of --; -------

6 DATE OF BIRTH (month, day, and year) May 8, 1905.

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 21 | 10 | 18 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer) B.Md.R.R.Co.

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER William Hiller.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Norfolk, Va.

12 MAIDEN NAME OF MOTHER Anna Gornowitz.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany.

14 Informant Anna Hiller.(mother)

(Address) 2119 Hanover St.

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

By

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Endocarditis.

Acute dilatation of the Heart.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) Otto M Reinhardt M. D.
(Coroner)

3/28, 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Leadenhall 3/29 1927 Date of Burial

20 UNDERTAKER Drew McCully. ADDRESS 118 Eastern Ave

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

2 20650

## CERTIFICATE OF DEATH.

129 E 20650

1-PLACE OF DEATH St Joseph's Hospital.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 10-14 ST., WARD)

2-FULL NAME Margaret Balzer.

(a) RESIDENCE NO. 1146 N Eden ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | white | widowed. |

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1862

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 65 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic. 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Record (Address)

Filed 2 8 1927 C. HAMPSON JONES, M. D. Registrar

Per RCH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/28 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 25, 1927, to March 28, 1927, that I last saw her alive on March 28, 1927, and that death occurred, on the date stated above, at 3-05 p m.

The CAUSE OF DEATH* was as follows:

Ch Nephritis.

Ch Myocarditis

Arteriosclerosis

(duration) 5 yrs. mos ds.

~~Broncho~~ Pneumonia

CONTRIBUTORY (Secondary) Myocarditis failure

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical observation

(Signed) Clement B. Norment, M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Annapolis Md

DATE OF BURIAL Mar 28 1927

20 UNDERTAKER Langley & Sons.

ADDRESS Annapolis Md.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

**E 20651**

CERTIFICATE OF DEATH.

14-001 **E 20651**

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 2030 W. Cullen St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bella Tolson

(a) RESIDENCE NO. 2030 W. Cullen St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? 1889

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 38 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER Frank Tolson

11 BIRTHPLACE OF FATHER (city or town): Md

(State or country)

12 MAIDEN NAME OF MOTHER Hentitia Douglass

13 BIRTHPLACE OF MOTHER (city or town): Md.

(State or country)

14 Informant: Mrs. Alvin Davis

(Address) Lakeland Md.

15 Filed 1927 C. HAMPSON JONES, M. D.

Per _____ Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ___ yrs. ___ mos. 1 ds.

CONTRIBUTORY (Secondary) no other history

(duration) ___ yrs. ___ mos. ___ ds.

(Signed) J. T. Hennessy M. D.

(Coroner)

March 27, 1927 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.,.....ds. In the State.....yrs.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Brandywine Md. Date of Burial 3/29/1927

20 UNDERTAKER: Chas. Alexander ADDRESS 1408 Druid Hill Ave

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20652

## CERTIFICATE OF DEATH.

167-09

E 20652

1-PLACE OF DEATH

City of BALTIMORE: (No. 3703 Cedardale Road St.) 15-67 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lucian A. Rudasill

(a) RESIDENCE NO. 3703 Cedardale Road St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ruth K. Davis

6 DATE OF BIRTH (month, day, and year) Feb. 11, 1876

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 51 | 1 | 15 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Retail Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) Madison Co., Va.

PARENTS

10 NAME OF FATHER James Rudasill

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Sarah Carpenter

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) ?

14 Informant Mrs. Ruth K. Rudasill

(Address) 3703 Cedardale Road

15 1927 C. HAMPSON JONES, M. D.

Per R.K.W. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Caused by gas poisoning self inflicted

(duration) ____ yrs. ____ mos. 1 ds.

CONTRIBUTORY (Secondary) gas asphyxia

(duration) 2 yrs. ____ mos. ____ ds.

(Signed) C. T. Hennessy M. D. (Coroner)

3/27/1927 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?_____

Former or usual residence_____

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Woodlawn Cemetery | Mar. 29 1927 |

20 UNDERTAKER Henry W. Mears & Son ADDRESS 805 N. Calvert St.

Cor.—12-9-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20653

## CERTIFICATE OF DEATH.

14 Feb

E 20653

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 6-9 Ward)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Myrtle Henry

(a) RESIDENCE NO. 1752 Mulikin St St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | col | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hanson Henry

6 DATE OF BIRTH (month, day, and year) May 26/1896

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 30 | 9 10 | 26 0 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Balto. Md

PARENTS

10 NAME OF FATHER James Covell

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Balto., Co., Md

12 MAIDEN NAME OF MOTHER Eleanora Burman

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Balto., Md.

14 Informant Hanson Henry

(Address) 1752 Mulikin St

15 Filed C. HAMPSON JONES, M. D. 19

8 1927 Per _____ Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 20/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock- Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Placentia Praevia

(duration) yrs. mos. ds.

(Signed) _____ M. D.

(Coroner)

3/28/27 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ashurst Cemetery Date of Burial Mar 30 1927

20 UNDERTAKER Robert E. Williams ADDRESS 515 W Oliver

Spec. 7-17-26—A Co.—200 Bks.

E 20654

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 20654

REGISTERED NO. 1001

1-PLACE OF DEATH

City of BALTIMORE: (No. 520 S Ann St 7-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Genevie Sarzynski

(a) RESIDENCE NO. 520 S Ann St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Singie |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 4 1926

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|---|
| | | 10 | 24 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particolar kind of work ..... None

(b) General nature of indostry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) .....

(State or country) Balto Md

PARENTS

10 NAME OF FATHER Joseph Sarzynski

11 BIRTHPLACE OF FATHER (City or town) .....

(State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Boroch

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) Poland

14 Informant Mary Sarzynski

(Address) 520 S Ann St

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

March 28 1927

17 I HEREBY CERTIFY, That I attended deceased from March 8, 19 27, to March 27, 19 27,

that I last saw h.. alive on March 27, 19 27,

and that death occurred, on the date stated above, at 5.30 a.m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Inanition

(duration) ..... yrs. 2 mos. ..... ds.

18 Where was disease contracted

If not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? P. S. V. S.

(Signed) John J Kraus, M. D.

, 19 (Address) 9627 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

St Nicholas March 27 19 27

20 UNDERTAKER — ADDRESS

John M Weber 1503 Eastern Ave

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20655

100-901

E 20655

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2824 Hudson St. 11 Ward)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dorothy Stanworth

(a) RESIDENCE NO. 2826 Hudson St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | white | single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 26 / 27

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | | 2 | 2 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nursing Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Salt Lake City

(State or country)

PARENTS

10 NAME OF FATHER John Stanworth

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Salt Lake City

12 MAIDEN NAME OF MOTHER Josephine Ronsch

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ga

14 Informant Josephine Stanworth

(Address) 2824 Hudson

15 Filed 3 1927 C. HAMPSON JONES, M. D.

Per R.H.H. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquisition (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) .....yrs. .....mos. 6 ds.

CONTRIBUTORY (Secondary) Acute Congestion of Lungs

(duration) .....yrs. .....mos. 1 ds.

(Signed) James W. Fenton M. D.

(Coroner)

3 28 1927 (Address) 701 E Eden St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem Date of Burial 3 29 1927

20 UNDERTAKER John M Weber ADDRESS 803 Bond St

Spec.—1-10-21—M&T—1500 Blks. Constanty Turowski

# HEALTH DEPARTMENT—CITY OF BALTIMORE

20656 E 20656

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Maryland General Hospital REGISTERED NO.

CITY OF BALTIMORE: (No.) 24-33 ST. (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Constanty Turowski

(a) RESIDENCE No. 1503 E. Clement St. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 17, 1881

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 45 | 6 | 12 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Upholsterer 031

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Wm Turowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Serezen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Harper Evans

15 Filed 8 1927, 19 [illegible] Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26 1927

17

I HEREBY CERTIFY, That I attended deceased from March 17, 1927, to March 26, 1927, that I last saw him alive on March 26, 1927, and that death occurred, on the date stated above, at 7:15 P. m.

The CAUSE OF DEATH* was as follows:

Ruptured Duodenal Ulcer

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 3-20-27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Thos A Dougherty, M. D.

, 19 (Address) 1503 E Clement St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary March DATE OF BURIAL 30 1927

20 UNDERTAKER John M Wilen ADDRESS 1853 Gough

H. HAMPSON JONES, M. D.

Spec.—1-12-23—M&T—500 Blks.

E 20657

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

101-001

E 20657

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital ST. 1-1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Laura Sliwinska

(a) RESIDENCE NO. 703 S. Decker Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? 6 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Michael Sliwinska

6 DATE OF BIRTH (month, day, and year): Feb 8 - 1902

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 25 | 1 | 18 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 037

(b) General nature of industry, business, or establishment in which employed (or employer): Housework

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): ~~Miss~~ Biloxy Miss

PARENTS

10 NAME OF FATHER: Walter Zogik

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Julia Sliva

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland not given

14 Informant: Michael Sliwinska

(Address): 703 S Decker Ave

15 Filed 2 8 1927, 19 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3-27 1927

17 I HEREBY CERTIFY, That I attended deceased from 3-23, 1927, to 3-27, 1927, that I last saw her alive on 3-27, 1927, and that death occurred, on the date stated above, at 7a. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) J. Theron Hunter, M. D.

3/27. 1927 (Address) St. Agnes' Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Holy Rosary Parish | March 30 1927 |
| 20 UNDERTAKER | ADDRESS |
| Thos W Weber | 1113 Gay St |

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20658

# CERTIFICATE OF DEATH.

E 20658

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St. 26-37 Ward)

2-FULL NAME John A Hild.

(a) RESIDENCE NO. Road Side Essex Md St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred: yrs. mos. 1 ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M. | W. | Single |

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sep 5. 1862

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 64 | 6 | 21 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Farm Hand

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Frank Castler

(Address) Woodbourne Balto Co.

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) May 26 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

* Chronic Endo-

Carditis & Contusions of Kidney

(duration) yrs. mos. days.

CONTRIBUTORY Shock

(Secondary)

(duration) 2 yrs. 6 mos. ds.

Signed M. D.

(Coroner)

May 27 1927 (Address) 1473 Bank St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Holy Redeemer Cem | 3/30 1927 |
| **20 UNDERTAKER** | **ADDRESS** |
| J. G. Connelly | Essex Md |

Spec.—1-10-21—M&T—1500 Bks.

E 20659

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20659

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Franklin Square Hospital

REGISTERED NO. 166

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. 14-7 WARD)

2-FULL NAME Lillian J. Buckingham

(a) RESIDENCE NO. Sykesville, R. F. D. #1 ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 5 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| F. | W. | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feby. 2 1908

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 19 | 1 | 26 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Factory Hand

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Sykesville, Md.
(State or country)

PARENTS

10 NAME OF FATHER James Buckingham

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Kate E. Criswell.

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Maryland.

14 Informant James T. Buckingham.
(Address) Sykesville Md.

15 Filed 8 1927 C. HAMPSON JONES, M. D.
By ..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-28 1927

I HEREBY CERTIFY, That I attended deceased from 3-7 .1927. to 3-28 .1927.

that I last saw her alive on 3-28 .1927.

and that death occurred, on the date stated above, at 8 35 A. m.

The CAUSE OF DEATH* was as follows:

Bichloride poisoning (oral)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James T. Hyman M. D.

.19 (Address) Franklin Square Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Carrollton, Md. Bethesda Cemetery.

DATE OF BURIAL Mar 30 1927.

20 UNDERTAKER C. M. Waltz.

ADDRESS Westfield, Md.

Coroner's Case No. 1927
Permit Issued 3/31/27

Cor.—12-9-25—A Co.—200 Bks.

Dr Hennessy 1-001

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 20660

E 20660

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hospital St., 14 Ward) 14-59

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Klingfelter

(a) RESIDENCE NO. 2122 Pennsylvania Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | W. | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Simon Klingfelter

6 DATE OF BIRTH (month, day, and year) Nov 11, 1843

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 83 | 3 | 16 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Hanover

(State or country) Pa

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Pa

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Pa

14 Informant Harry L Klingfelter.

(Address) 2122 Pennsylvania Ave

Filed 12 9 1927 Per C. HAMPSON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 7 yrs. mos. ds.

(Signed) D. T. Hennessy, M. D. (Coroner)

Dated Nov 29 1927 (Address) 507 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hanover, Pa Date of Burial Nov 30 1927

20 UNDERTAKER W. C. Cook ADDRESS 507 E Fayette

Spec.—1-10-21—M&T—1500 Bks.

E 20661

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 20661

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1969 Patterson Place ST., 8-45 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia T Anderson

(a) RESIDENCE No. 1969 Patterson Place ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | W | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William E Anderson

6 DATE OF BIRTH (month, day, and year) July 13. 1910

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 16 | 8 | 15 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Joseph A Eberle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Marcella Kraus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York City

14 Informant Barbara Barkman
(Address) 1708 Bristol Ave

15 Filed MAR 29 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28 1927

17

I HEREBY CERTIFY, That I attended deceased from March 25, 1927, to March 28, 1927, that I last saw her alive on March 28, 1927, and that death occurred, on the date stated above, at 9:15 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Fred C Demuth M. D.

, 19 (Address) 2516 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Hill Cem

DATE OF BURIAL March 31 1927

20 UNDERTAKER Pott & Turner Inc

ADDRESS 1442 N Broadway

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 20662

## CERTIFICATE OF DEATH.

E 20662

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 1-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles C. Bewig

(a) RESIDENCE NO. 2922 Elliott St St. 1 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred __ yrs. __ mos. __ ds. How long in U. S., if of foreign birth? __ yrs. __ mos. __ ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dec 27/26

6 DATE OF BIRTH (month, day, and year)

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | | 3 | 0 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Kenneth Bewig

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto., Md

12 MAIDEN NAME OF MOTHER Lorretta Jeffers

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto., Md

14 Informant Kenneth Bewig

(Address) 2922 Elliott St

15 Filed MAR 29 1927 C. HAMPSON JONES, M. D.

Per _____ Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 27/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) did that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (primary)

(Autopsy at Hopkins Hospital)

(duration) __ yrs. __ mos. __ ds.

CONTRIBUTORY (Secondary) _____

(duration) __ yrs. __ mos. __ ds.

(Signed) J. H. Collins M. D.

(Coroner)

3/28/27 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death __ yrs. __ mos. __ ds. In the State. __ yrs. __ mos. __ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Druid Hill Cem Mar 29 1927

20 UNDERTAKER ADDRESS

Stephen F. Galkowski Pleasant

Spec.–7-17-2[illegible] [illegible]00 Blk.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 20663 49 E 20663

1-PLACE OF DEATH Colonial Hosp.

REGISTERED NO.

City of BALTIMORE: (No. 1122 W. Mount. St. 2435 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Albers

(a) RESIDENCE NO. 1300 Towson St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Johanna Albers

6 DATE OF BIRTH (month, day, and year) Dec 20 - 1857

| 7 AGE | Years | Months | Days | IF LESS than 1 day ... hrs. or ... min. |
|---|---|---|---|---|
| | 75 | 7 | 8 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Night Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) 06

(c) Name of employer

9 BIRTHPLACE (city or town) ...

(State or country) Germany

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (City or town) ...

(State or country) Germany

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (City or town) ...

(State or country) Germany

14 Informant Mrs F. Sauter

(Address) 20 S. Robinson

15 Filed ... C. HAMPSON JONES M D Registrar

MAR 29 1927 Per ...

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/28 1927

17 I HEREBY CERTIFY, That I attended deceased from 3/14 1927 to 3/28 1927

that I last saw h/2 alive on 3/28 1927

and that death occurred, on the date stated above, at 3:35 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary) Cancer of bladder

(duration) ? yrs. ? mos. ? ds. (Aut.)

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of ...

Was there an autopsy? Yes

What test confirmed diagnosis? Phys. Exam

(Signed) John L. Bruce, M. D.

, 19 (Address) Colonial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Schwartz Cem | 3/31 1927 |
| 20 UNDERTAKER John Merrick | ADDRESS Eastern |

Cor.—12-9-25—A Co.—200 Bks.

**E 20664**

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

22-6 129

**E 20664**

REGISTERED NO. _____

1-PLACE OF DEATH

City of BALTIMORE: (No. Stmr. Joppa Pier No. 9 Light St. Wharf Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William A. Hodges.

(a) RESIDENCE NO. Stmr. Joppa Pier 9 Light St. Wharf. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. ---- mos. ---- ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male. | White. | Single. |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 55 | -------- | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman.

(b) General nature of industry, business, or establishment in which employed (or employer) Stmr. Joppa.

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Bristol, Md.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Do not know.

14 Informant John H. Yett. (nephew)

(Address) 640 S. Clement st.

15 Filed AUG 29 1926 HAMPSON JONES, M. D.

Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy & inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary Sclerosis, acute Myocarditis & dilatation, general Uterio sclerosis Chronic Nephritis.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) _____

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt M. D. (Coroner)

8/28 1927 (Address) 1017 S. Charles st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem't Date of Burial 4/29 1927

20 UNDERTAKER Edward Evans ADDRESS 566 E. Fayette

Spec.—1-12-23—M&T—500 Bks.

E 20665

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20665

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 4135 Falls Road ST., 13 WARD)

REGISTERED NO. 12-527 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillie D. Morfoot

(a) RESIDENCE No. 4135 Falls Road ST., 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 10 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas Morfoot

6 DATE OF BIRTH (month, day, and year): May 6-1883

7 AGE — Years: 43 | Months: 10 | Days: 20 | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: John B. Edrington

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Mollie Booker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mrs. Lola M. Gray

(Address) 1014 E. 38th St.

15 Filed ..... 19 ..... Per ..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 26 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 19, 1923 to March 26, 1927.

that I last saw h.. alive on March 26, 1927.

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Myocarditis, Endocarditis

(duration) ~~4~~ yrs 1/2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Frank H Lamb, M. D.

, 19 (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge — DATE OF BURIAL: March 29 1927

20 UNDERTAKER: Horace F. Burgee — ADDRESS: 1431 Falls Road

MAR 29 1927 C. HAMPSON JONES, M. D.

Spec.—1-12-23—M&T—500 Bks.

E 20666

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

38 E 20666

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Josephs Hospital

CITY OF BALTIMORE: (No.) Caroline & Oliver ST. 14-20 (WARD)

2-FULL NAME Margaret Ali

(a) RESIDENCE NO. 1619 Pennsylvania Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 21 - 1901

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| 25 | 25 | 4 | 6 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: actress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): New York City.

10 NAME OF FATHER Robt Carr.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Brooklyn.

12 MAIDEN NAME OF MOTHER Lila Walker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ga.

Informant: Robt Carr

(Address) Brooklyn N. York

Filed APR 29 1927 19 W. HAMPSON JONES, M. D.

Per Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26 1927

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1927, to March 26, 1927, that I last saw her alive on March 26, 1927 and that death occurred, on the date stated above, at 1:05 p. m.

The CAUSE OF DEATH* was as follows:

Myocarditis. nephritis — hepatitis

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? — Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Clinical

(Signed) Frank Hilliard, M. D.

, 19 (Address) 11 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: 3/29/27

UNDERTAKER: Samuel Brusley

ADDRESS: [illegible]

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20667

E 20667

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2450 Druid Hill ave (ST.) (WARD) 59

REGISTERED NO. 100-6

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cornelius Lee

(a) RESIDENCE NO. 2450 Druid Hill Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 2 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 19-1925

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 2 | 2 | 7 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER Eugene Wells

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Corrie Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Clara Lee (Address) 2450 Druid Hill ave

15 Filed 1927 C. HAMPSON JONES, Dr. H. Registered

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 26 1927

17

I HEREBY CERTIFY, That I attended deceased from Mar 25, 1927, to Mar 26, 1927, that I last saw h alive on Mar 26, 1927, and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) — yrs — mos 3 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Harry F Brown, M. D.

3/29, 1927 Address 916 Penna ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem — DATE OF BURIAL: 3/29/27

20 UNDERTAKER: Emmert B Hawley — ADDRESS: Md Balto

Spec.-7-17-26—A Co.—200 Bks.

E 20668

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20668

## CERTIFICATE OF DEATH

90

1-PLACE OF DEATH

REGISTERED NO. 27-45

City of BALTIMORE: (No. 4206 Harford Ave Terrace St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martin Frederick

(a) RESIDENCE NO. 4206 Harford Ave Terrace St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Frederick

6 DATE OF BIRTH (month, day, and year) Nov. 17, 1861

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min.. |
|---|---|---|---|---|
| | 65 | 4 | 10 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber 59

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Peter Frederick

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine Reitz

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs Anna Wehe

(Address) 4206 Harford Ave Terrace

15 Filed MAR 29 1927, 19 HARRISON JONES, M. D.

Per K H Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27 19 27

17 I HEREBY CERTIFY, That I attended deceased from March 14th, 19 27, to March 27th, 19 27.

that I last saw him alive on March 27th, 19 27.

and that death occurred, on the data stated above, at 11 45 A. m.

The CAUSE OF DEATH* was as follows: Chronic Valvular Endocarditis

(duration) 5 yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) A. L. Gordy, M. D.

3-28 1927 (Address) 4218 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Lorraine Cemetery | March 30 1927 |
| 20 UNDERTAKER H. Sander & Sons | ADDRESS 1710 Mad Ave |

Spec.—12-9-25—A Co.—200 Bks.

Dr. Diehl

# HEALTH DEPARTMENT—CITY OF BALTIMORE

120 E 20669

20669

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1714 Webster St. 24 34 Ward)

2-FULL NAME Clara I. Robinson

(a) RESIDENCE NO. 1714 Webster St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 28th, 1910

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 16 | 4 | 24 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: works on machine

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Knop Stove Co.

9 BIRTHPLACE (city or town): Balto.

(State or country)

PARENTS

10 NAME OF FATHER Geo. W. Robinson

11 BIRTHPLACE OF FATHER (city or town): Balto.

(State or country)

12 MAIDEN NAME OF MOTHER Fredricka Kahler

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Balto.

14 Informant: Geo. W. Robinson

(Address) 1714 Webster St.

15 Filed APR 29 1927 HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25th 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 22nd, 1927, to March 25th, 1927, that I last saw h[illegible] alive on March 25th, 1927, and that death occurred, on the date stated above, at 5:15 p. m.

The CAUSE OF DEATH* was as follows:

I (a) Pneumonia of pregnancy Acute hyperplastic atrophy of liver 2)

(duration) yrs. 1 mos. 3 ds.

CONTRIBUTORY (Secondary) Acute endocarditis

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) I. M. Fleischer, M. D.

3/28, 1927 (Address) 1214 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Paul's German Cemetery — Date of Burial 3/29/1927

20 UNDERTAKER: C. J. Kenney & Son — ADDRESS 1936 Lafayette Ave.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20670

## CERTIFICATE OF DEATH.

90

REGISTERED NO. E 20670

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mt Hope Retreat ST. 25th WARD 23

2-FULL NAME Mary Byrne (Sister)

(a) RESIDENCE NO. Mt Hope Retreat ST. 25th WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred over 60 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? over 70 yrs. 0 mos. 0 ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single - |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs or ....min. |
|---|---|---|---|---|
| | 84 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sister of Charity 065

(b) General nature of industry, business, or establishment in which employed (or employer) Nursing -

(c) Name of employer Mt Hope Retreat

9 BIRTHPLACE (city or town) (?)
(State or country) Ireland

PARENTS

10 NAME OF FATHER Edward Byrne

11 BIRTHPLACE OF FATHER (city or town) (?)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Cullen

13 BIRTHPLACE OF MOTHER (city or town) (?)
(State or country) Ireland

14 Informant Records Mt Hope Retreat
(Address) Mt Hope Retreat Md.

15 Filed MAR 29 1927 By C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28th 1927

17

I HEREBY CERTIFY, That I attended deceased from March 20th, 1927, to March 28th, 1927.

that I last saw her alive on March 27, 1927.

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 0 yrs. 0 mos. 10 ds.

CONTRIBUTORY (Secondary), Chronic Arterio-Sclerosis.

3 (duration) 4 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Mt Hope Retreat

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Flannery, M. D.

March 28th 1927 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Hope Cemetery

DATE OF BURIAL March 29th 1927

50 UNDERTAKER D. STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

Spec.—1-10-21—M&T—1500 Blks.

E 20671

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20671

## CERTIFICATE OF DEATH.

128

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1 Nth th Mon ST. 17-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James L. Shook

(a) RESIDENCE NO. 1 Nth th Mon ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Pauline B. Shook

6 DATE OF BIRTH (month, day, and year): May 17, 1880

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 46 | 10 | 10 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Waiter 070

(b) General nature of Industry, business, or establishment in which employed (or employer): Cafe

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: James Shook

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Martha Tate

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Pauline B. Shook

(Address) 1 Nth th Mon

15 Filed MAR 29 1927 Registrar

C. HAMPSON JONES, M. D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 27th 1927

17 I HEREBY CERTIFY, That I attended deceased from March 23d, 1927, to March 27th 1927, that I last saw h alive on March 26th 1927, and that death occurred, on the date stated above, at 5:00 P.M.

The CAUSE OF DEATH* was as follows:

Int Carcinoma

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Int Disease

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?: —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

Signed: A. Lee Cole, M. D.

P. O. Address: 924 Mon. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery

DATE OF BURIAL: Mar 29 1927

20 UNDERTAKER: Jno. W. Johnson

ADDRESS 1234 Eutaw St.

Spec.–7-17-26—A Co.—200 Blks.

E 20672

# HEALTH DEPARTMENT—CITY OF BALTIMORE

129 E 20672

## CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 304 n. Bethel St. 6-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amos Boardley

(a) RESIDENCE NO. 304 n. Bethel St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1874

7 AGE: Years 53 Months Days IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer in Yard

(b) General nature of industry, business, or establishment in which employed (or employer): Balto. Brick Yard

(c) Name of employer: Balto. Brick Co.

9 BIRTHPLACE (city or town): Balto

(State or country): md

PARENTS

10 NAME OF FATHER: George Boardley

11 BIRTHPLACE OF FATHER (City or Balto

(State or country): md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): Not Known

(State or country)

14 Informant: Mary Mosley

(Address) 92 S Rutland Ave

15 Filed ..... 19 ..... C. HAMPTON JONES, M. D. Registrar

Per .....

MAR 29 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 25, 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 21/27, 19 ..., to Mar 25, 19 27

that I last saw h. alive on Mar 25, 19 27

and that death occurred, on the date stated above, at 9.30 a. m.

The CAUSE OF DEATH* was as follows: Chronic Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): not known

(duration) yrs. mos. ds.

18 Where was disease contracted: not known

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) R L Ensminger M. D.

19 (Address) 815 E Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury cemetery

Date of Burial: mar 29 1927

20 UNDERTAKER: Edward Bryan

ADDRESS 1681 orleans st

Spec.—12-9-25—A Co.—200 4ks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20673

CERTIFICATE OF DEATH

E 20673

REGISTERED NO.

1-PLACE OF DEATH Balto City Hospitals 100-001

City of BALTIMORE: (No. Balto. Md. 10-37 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Kellum

(a) RESIDENCE NO. Unknown St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Black

5 Single, Married, Widowed, or Divorced. (Write the word): Separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 65? | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Texas

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Balto City Hospitals

ADDRESS Baltimore Md

15 Filed 3 29 1927 19 C. HAMPSON JONES, M. D.

By Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-27 19 27

17 I HEREBY CERTIFY, That I attended deceased from 1-18 19 27 to 3-27 19 27

that I last saw him alive on 3-27 19 27

and that death occurred, on the date stated above, at 3.40 P. m.

The CAUSE OF DEATH* was as follows:

Terminal Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pachymeningitis w/ Cerebral Arteriosclerosis + Hypertension

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Harry Goodman M.D.

3/28 19 27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Albany Cem. Date of Burial 3/30 19 27

20 UNDERTAKER Byron Wright ADDRESS 1218 W. Baltimore

Spec.—12-9-25—A Co.—200 Blks.

E 20674

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 ✓

E 20674

REGISTERED NO.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. 1724 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Keyes

(a) RESIDENCE NO. 442 St. Mary St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | Married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown 1873

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 54 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant

(Address) Records

15 Filed 2-9-1927, 19 H. CAMPBELL JONES, M.D.

By Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 1927

17

I HEREBY CERTIFY, That I attended deceased from March 14, 1927, to March 25, 1927, that I last saw him alive on March 25, 1927, and that death occurred, on the date stated above, at 3.50 P m.

The CAUSE OF DEATH* was as follows:

Arterial Sclerosis

Chronic Myocarditis Chronic

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) yrs. mos. ? ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Gennal & Laboratory

(Signed) R Hooper Lovell M. D.

Mar 26 27 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — Date of Burial Mar 29 1927

20 UNDERTAKER Mrs. R. G. Elliott — ADDRESS 1725 Ashland Ave

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20675

## CERTIFICATE OF DEATH.

128

REGISTERED NO. E 20675

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1876 N. Spring St. 5-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Harris

(a) RESIDENCE NO. 1876 N. Spring ST. WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | C | Married |

5a If married, widowed, or divorced
(or) WIFE of Nelson Harris

6 DATE OF BIRTH (month, day, and year) July 19, 1869

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 57 | 8 | 12 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co. Md.

PARENTS

10 NAME OF FATHER Willis Wisel

11 BIRTHPLACE OF FATHER (city or town) (State or country) ? Maryland

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Helen Harris
(Address) 1876 N. Spring

15 Filed APR 29 1927 C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 26 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 11, 1927, to Mar 26, 1927, that I last saw her alive on Mar. 25, 1927, and that death occurred, on the date stated above, at 1:30 A m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis
Acute Nephritis

(duration) yrs. 2 mos 15 ds.

CONTRIBUTORY (Secondary) Anemia & Chronic Pulmonary oedema

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam

(Signed) W. L. Berry, M. D.

, 19 (Address) 1520 E. Monument

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Calvary — DATE OF BURIAL Mar 29 1927

20 UNDERTAKER Mrs. R. G. Elliott — ADDRESS 1725 Ashland Ave

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

148 ✓

## CERTIFICATE OF DEATH.

E 20676 — 1-PLACE OF DEATH

REGISTERED NO. E 20676

City of BALTIMORE: (No. JOHNS HOPKINS HOSP. St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Curtis

(a) RESIDENCE NO. 508 Aisquith St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: William Curtis

6 DATE OF BIRTH (month, day, and year): Mar 10 1908

7 AGE — Years: 19 — Months: — Days: 17 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country): Md

PARENTS

10 NAME OF FATHER: Stewart —

11 BIRTHPLACE OF FATHER (city or town):

(State or country): —

12 MAIDEN NAME OF MOTHER: Carolin Fockers

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): —

14 Informant: Records —

(Address): JOHNS HOPKINS HOSPITAL

15 Filed ....., 19 ..... C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 27 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 24, 1927, to Mar 27, 1927, that I last saw h[illegible] alive on Mar. 27, 1927, and that death occurred, on the date stated above, at 3-05 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia - Bilateral lobar, post-operative following operative delivery by craniotomy. (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Eclampsia. Intra-partum infection of uterus with gas bacillus. (duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Mar 25, 1927

Was there an autopsy? Yes.

What test confirmed diagnosis? —

(Signed) J. C. Hoerner, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvary Cem. Date of Burial Apr. 1st 1927

20 UNDERTAKER: Mrs. R. L. Elliott ADDRESS 1725 Ashland Av

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20677

E 20677

## CERTIFICATE OF DEATH.

101-006

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [illegible] St., 196-1 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clinton Redd

(a) RESIDENCE NO. 921 South 2nd St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1901 Unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 26 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Virginia

PARENTS

10 NAME OF FATHER Samuel Redd

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Va

12 MAIDEN NAME OF MOTHER Maria —

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Va

14 Informant:

(Address) Records

15 Filed....., 19.... C. HAMPSON JONES, M. D., Registrar

R 2 9 1927 Per. [illegible]

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26 1927

17 I HEREBY CERTIFY, That I attended deceased from March 21, 1927, to March 26, 1927, that I last saw him alive on March 25, 1927, and that death occurred, on the date stated above, at 6 35 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Laboratory

(Signed) R Hooper Lamb, M. D.

March 28 27 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cemetery — Date of Burial: Mar 30 1927

20 UNDERTAKER: Mrs R. A. Elliott — ADDRESS: 1725 Ashland Ave

Spec.—1-10-21—M&T—1500 Bks.

E 20678 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 20678

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Md. General Hospital (St.) 16-11 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Lillie Smith.

(a) RESIDENCE NO. Curtis Bay, Maryland (St.) WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. 9 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| F. | W | Married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 17, 1881

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 46 | 9 | 11 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. W.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Char. Bathgate

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Scotland

12 MAIDEN NAME OF MOTHER Eliz. Mullineaux

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Hospital Records.
(Address)

15 Filed 2 9 1927 By C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-28-1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 18, 1927, to March 28, 1927, that I last saw her alive on March 26, 1927, and that death occurred, on the date stated above, at 3.20 P. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerotic Nephritis

(duration) about 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) Known yrs. mos. 3d ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? Yes Date of 3-24-27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Melville Cemetery

DATE OF BURIAL Mar. 30 1927

20 UNDERTAKER Elridge Md

ADDRESS 231 Md. Ave Westport.

Nelson E. Stiles

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20679

## CERTIFICATE OF DEATH.

160 E 20679

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 416 Loudon Ave., ST. 20-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Paul Sordelett

(a) RESIDENCE NO. 416 Loudon Ave., ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: None

6 DATE OF BIRTH (month, day, and year): December 14, 1926

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | | 3 | 14 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Peter Sordelett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Richmond Va.

12 MAIDEN NAME OF MOTHER: Virginia Hickman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore, Md.

14 Informant: Mr. Peter Sordelett

(Address): 416 Loudon Ave.

15 Filed ..., 19... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar. 28 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 19 27. to March 27. 19 27.

that I last saw him alive on March 27. 19 27.

and that death occurred, on the date stated above, at 11.00 a.m.

The CAUSE OF DEATH* was as follows:

Coarctation Aorta

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Geo L. Mosser, M. D.

, 19 (Address) 4008 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: Mar. 29 1927

20 UNDERTAKER: Nelson E. Stiles — ADDRESS: 231 Md. Ave Westport.

MAR 29 1927 C. HAMPSON, M.D.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

19227
E 20680

31 E 20680

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPL. St. 1521 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Burley

(a) RESIDENCE NO. 1707 N. Mount St. City Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1900

7 AGE: Years 27 | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of Industry, business, or establishment in which employed (or employer): 021

(c) Name of employer

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER: John Burley

11 BIRTHPLACE OF FATHER (city or town): Md.

(State or country)

12 MAIDEN NAME OF MOTHER: Saxon

13 BIRTHPLACE OF MOTHER (city or town): Md

(State or country)

14 Informant: Records

(Address) JOHNS HOPKINS HOSPL.

Filed MAR 29 1927 HAMPSON, Jones M. Registrar.

Per RR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar. 28 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan. 13, 1927, to Mar. 28, 1927, that I last saw her alive on Mar. 28, 1927, and that death occurred, on the date stated above, at 6 50 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis.
Tuberculous peritonitis.
Tuberculous perforation of bowel.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Fecal fistula. Peritonitis (B. Coli). Inanition.

(duration) yrs. 1 mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Feb. 14, 1927.

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) R. L. Faulkner, M. D.

, 19 Address JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Md Date of Burial March 30. 27

20 UNDERTAKER: Daniel Carson ADDRESS 916 Ea ave.

Spec.—1-10-21—M&T—1500 Bks.

Belt,

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20681

## CERTIFICATE OF DEATH.

E 20681

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 718 W Mulberry St., 17th 129 (WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Brown Britt

(a) RESIDENCE No. 718 W Mulberry St., ..... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Annie Britt

6 DATE OF BIRTH (month, day, and year): March - 1874

7 AGE: Years 53 | Months - | Days - | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): A & C Co Maryland

PARENTS

10 NAME OF FATHER: Thomas Britt

11 BIRTHPLACE OF FATHER (city or town) (State or country): A & C Co Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): —

14 Informant: Annie Britt (Address) 230 N Arlington Ave

15 Filed APR 29 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 28 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 29, 1926 to March 28, 1927, that I last saw him alive on March 28, 1927, and that death occurred, on the date stated above, at 11.30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) W H Neville M. D.

(Address) 119 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem

DATE OF BURIAL: March 30/1927

UNDERTAKER: Daniel Carlon

ADDRESS 94 Laure

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20682

## CERTIFICATE OF DEATH.

E 20682

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1906 W. Fay ave ST. 14-20 WARD)

2-FULL NAME Catherine B. Blackwell

(a) RESIDENCE NO. 1906 W. Fay ave ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F. | Colored | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harvey Blackwell

6 DATE OF BIRTH (month, day, and year) 1901

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or ..... min. |
|---|---|---|---|---|
| | 26 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Ch Rom

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balt. Md.

PARENTS

10 NAME OF FATHER Chas. Owens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Matilda Tyler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Harvey Blackwell
(Address) 1906 W. Fay ave

Filed MAR 29 1927 HAMPSON JONES, M.D.
Registrar

Per .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27 1927

17 I HEREBY CERTIFY, That I attended deceased from 3/24/27, 1927, to 3/27/27, 1927, that I last saw him alive on March 26, 1927, and that death occurred, on the date stated above, at 4 A.M. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Hypostatic Congestion

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Ellis, M. D.

3/29, 1927 (Address) 924 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

UNDERTAKER Samuel Carlson

DATE OF BURIAL March 31/1927

ADDRESS 946 Lee ave

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

74001

E 20683 — REGISTERED NO. E 20683

1-PLACE OF DEATH

City of BALTIMORE: (No. 335 S. Third St. St. 26-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Roder.

(a) RESIDENCE NO. 335 S. Third St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William Roder.

6 DATE OF BIRTH (month, day, and year): July 10-1864

7 AGE — Years: 62 — Months: 8 — Days: 16 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Germany.

PARENTS

10 NAME OF FATHER: John Mueller

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Germany.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany.

14 Informant: Emma Schoepflin Daughter

(Address): 335 S. Third St.

15 Filed: March 28 1927 — C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March-26-1927

17 I HEREBY CERTIFY, That I attended deceased from March 23 1927, to March 26 1927, that I last saw h[illegible] alive on March 26th 1927, and that death occurred, on the date stated above, at 8:35 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Uraemia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. H. Jones, M. D.

March 28 1927 (Address) 1504 E. Eager St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Sacred Heart Cem March 30 1927

20 UNDERTAKER — ADDRESS

Lilly & Zeiler 403 S. Wolfe St

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20684

## CERTIFICATE OF DEATH

× 100-091

E 20684

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. 30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Stanton

(a) RESIDENCE NO. Frostburg Md St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Wid.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 56 Months Days IF LESS than 1 day ...hrs. or ...min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) W. Va.

PARENTS

10 NAME OF FATHER Thomas Stanton

11 BIRTHPLACE OF FATHER (City or town) Pa

(State or country)

12 MAIDEN NAME OF MOTHER Mary Broadwater

13 BIRTHPLACE OF MOTHER (city or town) ?

(State or country)

14 Informant University Hospital

(Address)

15 Filed ... 19... Per ... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 March 17, 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 26, 1927, to March 17, 1927,

that I last saw h[illegible] alive on March 17, 1927

and that death occurred, on the date stated above, at 5 00 P. m.

The CAUSE OF DEATH* was as follows:

Bronchitectasis

Hypotension

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Terminal Bronchopneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical diagnosis X-Ray

(Signed) Jacob Rheinstein, M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

UNIVERSITY OF MARYLAND.

C. HAMPSON JONES, M.D. Commissioner of Health.

MAR 28 1927

Per. Wm. E. WOODALL

9 1927 Per ARH Registrar

1206

Very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—250 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20685

## CERTIFICATE OF DEATH.

38 ✓ E 20685

REGISTERED NO.

1-PLACE OF DEATH Balto City Hospls

City of BALTIMORE (No.) Balto Md (Sec.) 5-8 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Smith

(a) RESIDENCE NO. 122 Colvin St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or race: Black

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 43 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Balto City Hosps

(Address) Balto Md

Filed ....., 19 .....

1205 Per WPA Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927

3-27 27

17 I HEREBY CERTIFY, That I attended deceased from 3-24- , 1927 to 3-27- , 1927

that I last saw him alive on 3-27- , 1927

and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

General Paralysis of Insane

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Luetic Infection

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) New to Hospital M. D.

, 19 (Address) Balto City Hosp Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 1927

20 UNDERTAKER ADDRESS

UNIVERSITY OF MARYLAND. MAR 2 5 1927

C. HAMPSON JONES, M. D.

Commissioner Health.

Spec.—7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20686 101-001 E 20686

## CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 917 W. Lexington St. 18-26 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Harrison

(a) RESIDENCE NO. 917 W. Lexington St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. — mos. — ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced. (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec - 11 - 1887

7 AGE: Years 39 Months 3 Days 17 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Day's work

(b) General nature of industry, business, or establishment in which employed (or employer): in private

(c) Name of employer: families

9 BIRTHPLACE (city or town): Newsoms

(State or country): Virginia.

PARENTS

10 NAME OF FATHER: Richard Harrison

11 BIRTHPLACE OF FATHER (City or town): Dinwiddie Co.

(State or country): Virginia

12 MAIDEN NAME OF MOTHER: Nadine White

13 BIRTHPLACE OF MOTHER (City or town): Dinwiddie Co

(State or country): Virginia

14 Informant: Josephine Branch

(Address): 922 W Lexington St

15 Date: 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/28 1927

17 I HEREBY CERTIFY, That I attended deceased from 3/19, 1927, to 3/28, 1927, that I last saw her alive on 3/28, 1927, and that death occurred, on the date stated above, at 9:30 a. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) — yrs. — mos. 11 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? NO. Date of

Was there an autopsy? NO.

What test confirmed diagnosis? None

(Signed) D. and Francis M. D.

3/29, 1927 (Address) 122 W Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn St — Date of Burial: March 30 1927

20 UNDERTAKER: H. L. Bloom's Son — ADDRESS: 108 N. Monroe

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

20687

## CERTIFICATE OF DEATH.

20687

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1309 W Lombard St., (ST.) (WARD) 41-29

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis A Elphring,

(a) RESIDENCE NO. 1309 W Lombard St. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Susan E. (nee Pierce)

6 DATE OF BIRTH (month, day, and year) Nov. 5, 1857

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 69 | 4 | 23 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bailiff

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER William H. Elphring

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Eliaabeth Gardner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Francis A. Elphring Jr.

(Address) 1309 W Lombard St.

15 Filed 9 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 28 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 1, 1927, to Mar 28, 1927, that I last saw h— alive on Mar 28, 1927, and that death occurred, on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Int. Nephritis.

(duration) — yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) None

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinic Analysis, etc.

(Signed) Thos Hoyt Kerr, M. D.

3/29, 1927 (Address) 888 W Lombard St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery.

DATE OF BURIAL 3/30/27

20 UNDERTAKER Harry H Wirtz

ADDRESS 1531 W Lombard

Spec.—12-9-25—A Co.—200 Bks.

E 20688

# HEALTH DEPARTMENT—CITY OF BALTIMORE

36-005

E 20688

## CERTIFICATE OF DEATH.

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospitals Ward 16-67)

2-FULL NAME Philip Miller

(a) RESIDENCE NO. 1011 Bowley St. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Wid

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1851

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 76 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Germany

(State or country)

PARENTS

10 NAME OF FATHER: John Miller

11 BIRTHPLACE OF FATHER (city or town): Germany

(State or country)

12 MAIDEN NAME OF MOTHER: Bobon

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Germany

14 Informant: Hospital Record

(Address)

Filed 3-29-1927 C. HAMPSON JONES, M. D.

Per _____ Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 3-28-27

17 I HEREBY CERTIFY, That I attended deceased from 3-14- 19 27 to 3-28- 19 27,

that I last saw him alive on 3-28- 19 27

and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

Contributory Senility

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) _____

(duration) _____ yrs. _____ mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? _____

(Signed) W. Blizard M. D.

, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cemetery — Date of Burial 3-29 1927

20 UNDERTAKER: Mrs M Hunt — ADDRESS 213 Hanover

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20689

129 E 20689

## CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2541 Francis St. 13-59 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura Adele Falkenstein

(a) RESIDENCE NO. 2541 Francis St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Fredk Falkenstein

6 DATE OF BIRTH (month, day, and year): Dec. 18, 1843

7 AGE: Years 83 Months 3 Days 9

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Manchester. Md.

(State or country)

PARENTS

10 NAME OF FATHER Dr. Henry E. Betty

11 BIRTHPLACE OF FATHER (City or town): Md.

(State or country)

12 MAIDEN NAME OF MOTHER Julia Mottiers

13 BIRTHPLACE OF MOTHER (city or town): Md.

(State or country)

14 Informant: Mrs. Flora Baudholtz

(Address) 2543 Francis St

15 Filed 3-9 1927 C. HAMPSON JONES, M. D.

Per ARH Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 27 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 8, 1927, to Mar 27, 1927

that I last saw her alive on Mar 27, 1927

and that death occurred, on the date stated above, at 11.30 P m.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Interstitial Nephritis (duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examn

(Signed) Paul Brown, M. D.

3/28 1927 (Address) 1837 Pa. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem. Date of Burial: Mar 30 1927

20 UNDERTAKER: Wm. Pickuel & Sons ADDRESS: North Ave

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 20690 108 E 20690

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Union Memorial Hospital 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Amelie L. Charpentier

(a) RESIDENCE NO. 829 Hamilton Ter. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. da. How long in U. S. if of foreign birth? yrs. mos. da.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: J. Constant Charpentier

6 DATE OF BIRTH (month, day, and year): ?

7 AGE: Years 62 Months ? Days ? IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Teacher Governess

(b) General nature of industry, business, or establishment in which employed (or employer): Dr Joseph Blodgood

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): France

PARENTS

10 NAME OF FATHER: Francois Lefranc

11 BIRTHPLACE OF FATHER (City or town) (State or country): France

12 MAIDEN NAME OF MOTHER: Emilie Chaffiot

13 BIRTHPLACE OF MOTHER (city or town) (State or country): France

14 Informant (Address): Mrs Joseph Blodgood 904 N. Charles St Balto

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

3 1927 Per .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: March 28 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 28, 1922, to March 28, 1922, that I last saw h.e alive on March 28, 1922, and that death occurred, on the date stated above, at 9-12 P m.

The CAUSE OF DEATH* was as follows:

Ludwigs Angina

(duration) — yrs. — mos. 2 da.

CONTRIBUTORY (Secondary) Acute edema of glottis (duration) ..... yrs. ..... mos. 1 da.

18 Where was disease contracted if not at place of death? 829 Hamilton Terrace

Did an operation precede death? No Date of

Was there an autopsy? Yes at Johns Hopkins Hospital

What test confirmed diagnosis?

(Signed) Irvin Aldo Taynton, M. D.

, 19 (Address) Union Mem. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemetery — Date of Burial: Mar. 31 1927

20 UNDERTAKER: Wm Fickus & Sons — ADDRESS: North Ave

Spec.-7-17-26—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20691

E 20691

## CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH Woman's Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. 14-20 St., Ward)

2-FULL NAME Maria Washington Nichols

(a) RESIDENCE NO. Leesburg, Va. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. (Perm.) mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dr. Fenton M. Nichols

6 DATE OF BIRTH (month, day, and year) ~~Dec 3~~ Jan 10 1853

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|---|
| | 74 | 3 | 18 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Leesburg

(State or country) Va.

PARENTS

10 NAME OF FATHER Richard L Binkley

11 BIRTHPLACE OF FATHER (City or town) ?

(State or country)

12 MAIDEN NAME OF MOTHER Anne Catherine Drake

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Loudon Co. Va.

14 Informant J. Roberts Nilan

(Address) Balto Md

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

9 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29 19 27

17 I HEREBY CERTIFY, That I attended deceased from Mar. 28th 19 27, to Mar. 29, 19 27,

that I last saw her alive on Mar. 29, 19 27,

and that death occurred, on the date stated above, at 3 35 A m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known.

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Blood chemistry

(Signed) Edmund R Harrison Jr. M. D.

3/29 1927 (Address) Woman's Hosp. Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Leesburg Va

Date of Burial March 30 19 27

20 UNDERTAKER Henry H Jenkins & Son Co.

ADDRESS Cathedral & Madison Sts

Cor.—12-8-25—A Co.—200 Bks.

E 20692 HEALTH DEPARTMENT—CITY OF BALTIMORE E 20692

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 4101 Fernhill Ave St. 15-63 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis Schneider

(a) RESIDENCE NO. 4101 Fernhill Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Albert Schneider

6 DATE OF BIRTH (month, day, and year): Feb. 17, 1847

7 AGE — Years: 80 — Months: 1 — Days: 11 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Picture frames

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Germany

PARENTS

10 NAME OF FATHER: Nicholas Schneider

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Unknown

14 Informant: Louis Schneider

(Address): 4101 Fernhill Ave

15 Filed 1927 19

C. HAMPSON JONES, M. D.

Per Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 28 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) no other contributory

(duration) yrs. mos. ds.

(Signed) J. T. Ramsay M. D.

(Coroner)

(Address) 28 E. Lanvale St.

March 29 1927

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Date of Burial Mar 30 1927

20 UNDERTAKER: Mr. Mrs. J. W. Teufel & Son ADDRESS 801 W. Fayette

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

20693

## CERTIFICATE OF DEATH.

43 E 20693

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 330 S. Bond ST. 3-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles N. Roberto

(a) RESIDENCE NO. 330 S Bond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., If of foreign birth? 41 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emily Roberta

6 DATE OF BIRTH (month, day, and year) July 23 1866

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs. or ....min. |
|---|---|---|---|---|
| | 60 | 5 | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Thomas Roberto

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Rose Gonzaga

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant (Address) Emily Roberto 330 S Bond St

15 Filed 9 1927 C. HAMPSON JONES, M. D. Registrar

Par

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 28 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 6, 1926, to Mar 28, 1927, that I last saw h[illegible] alive on Mar 27, 1927, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Bowels

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? yes (Microscopic)

(Signed) Louis J. Pennetta, M. D.

29, 1927 (Address) 1058 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL April 2, 1927

20 UNDERTAKER Martin H. E Dippel — ADDRESS 378 Gunst

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

20694

## CERTIFICATE OF DEATH.

90E 20694

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2012 E Lombard ST. 2-24 WARD)

2-FULL NAME Walburga Moke

(a) RESIDENCE NO. 2012 E Lombard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | W. | Widow |

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Moke

6 DATE OF BIRTH (month, day, and year) July 6 1857

7 AGE

| Years | Months | Days | If LESS than 1 day, .... hrs. or .... min. |
|---|---|---|---|
| 69 | 8 | 22 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Joseph Kellner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER B. Hammerbacker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. B. Weber

(Address) 2012 E Lombard St.

15 Filed 9 1927 C. HAMPSON JONES, M. D. Register

By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 28 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 28, 1927, to Mar 28, 1927, that I last saw h.. alive on Mar 26, 1927, and that death occurred, on the date stated above, at 12 (?) m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Physical & Exhaustion

(Signed) Geo Lester Blanke, M. D.

, 19 (Address) 143 Forrest

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL March 31 1927

20 UNDERTAKER Martin W. & Dippel

ADDRESS 137 S Stre..

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 20695

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20695

## CERTIFICATE OF DEATH.

5-8 129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 646 W. Fairmount Ave. WARD)

2-FULL NAME Robert Byrd

(a) RESIDENCE. NO. 646 W. Fairmount ST. Ave. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | Colored | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 36 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter 070

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Washington D. C.

10 NAME OF FATHER William Byrd

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Lizzie Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hester Mitchell

(Address) 646 W. Fairmount ave

15 Filed 3 0 1927 16 C. HAMPSON JONES, M. D. Registrar

Per RK

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26, 1927

17

I HEREBY CERTIFY, That I attended deceased from March 19, 1927, to March 26, 1927, that I last saw him alive on March 26, 1927, and that death occurred, on the date stated above, at 4 30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(durntion) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of — —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & history.

(Signed) John D. Quinn, M. D.

3/26. 1927 (Address) 1507 N. Fulton ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Mt Lorne Cy | March 29 1927 |
| 20 UNDERTAKER Leonard Wheeler 306 | ADDRESS Myrtle ave |

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20696

## CERTIFICATE OF DEATH.

188-003

E 20696

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 4 Ward 7)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richie Ward

(a) RESIDENCE NO. East Falls Church Va. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 52 Months Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Proof-Reader

(b) General nature of industry, business, or establishment in which employed (or employer): U.S. Govt 063

(c) Name of employer

9 BIRTHPLACE (city or town): Va

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant: Mercy Hospital

(Address)

Filed 1927 C. HAMPSON JONES, M. D.

Per Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 27 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest, autopsy or inquiry. find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture femur

Gen arterio sclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism

(duration) yrs. mos. ds.

(Signed) H. J. Reilly M. D.

(Coroner)

March 30, 1927 (Address) 16 99 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death 1 yrs., 2 mos., 3 ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Falls Church Va Date of Burial 3/31 1927

20 UNDERTAKER: W. W. Chambers Co. ADDRESS 2. St.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20697

## CERTIFICATE OF DEATH.

E 20697

1-PLACE OF DEATH West Baltimore General Hospital

CITY OF BALTIMORE: (No. Raymond Dukeland ST.) 57-53 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leopold Bernstein

(a) RESIDENCE NO. 12 Old Spring Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Minnie Bernstein

7 DATE OF BIRTH (month, day, and year): [illegible]

| AGE | Years | Months | Days | If LESS than 1 day, hrs or min |
|---|---|---|---|---|
| | 53 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Dressed [illegible]

(b) General nature of industry, business, or establishment in which employed (or employer): Mens Clothing

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

10 NAME OF FATHER: Freyer Bernstein

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Minnie

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Jack Lewis 1489 Eutaw St

Filed 3 30 1927 per [illegible] Registrar

C. HAMPSON JONES, M. D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/30 1927

17 I HEREBY CERTIFY, That I attended deceased from 2/25 1927 to 3/30 1927

that I last saw h[illegible] alive on 3/30 1927

and that death occurred, on the date stated above, at 6 45 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(duration) yrs. 9 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Benjamin Miller, M. D.

, 19 (Address) W. B. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rodef Shalom

DATE OF BURIAL: 3/31 1927

20 UNDERTAKER: Jack Lewis

ADDRESS: 1489 Eutaw St

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

20698

101-001

E 20698

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 126 S. Robinson St., 1-2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Birdie B. Jones

(a) RESIDENCE NO. 126 S. Robinson Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

2 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: addie Jones

6 DATE OF BIRTH (month, day, and year): Dec. 4 1876

7 AGE — Years: 50 Months: 3 Days: 23 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sailor 086

(b) General nature of industry, business, or establishment in which employed (or employer): Local Harbor

(c) Name of employer: Annapurdel Co

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER: Ezekiel Jones

11 BIRTHPLACE OF FATHER (City or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER: Cath Trego

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant: addie Jones

(Address) 12 E. Hollins

15 Filed APR 30 1927, 19 HAMPSON JONES, M. D. Registrar

Per R.K.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 3/27/27

17 I HEREBY CERTIFY, That I attended deceased from 3/21, 1927, to 3/27, 1927, that I last saw h[illegible] alive on 3/27, 1927, and that death occurred, on the date stated above, at 10 30 P m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Temperature and pulse

(Signed) [illegible] M. D.

3-28, 1927 (Address) 315 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem. Date of Burial 3/30/1927

20 UNDERTAKER: J. A. Moran ADDRESS 3200 E. Baltimore

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20699

## CERTIFICATE OF DEATH.

E 20699
REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1708 N. Broadway ST. 8-17 WARD)

2-FULL NAME Charles C Paul

(a) RESIDENCE NO. 1708 N. Broadway ST. WARD
(Usual place of abode)
Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary L. Paul

6 DATE OF BIRTH (month, day, and year) May 24th 1845

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 81 | 10 | 5 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Ship Broker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) St Marys Co Md.

PARENTS

10 NAME OF FATHER C J. Paul

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dorchester Co Md

12 MAIDEN NAME OF MOTHER Luvilla Adams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St Marys Co Md

14 Informant Albert F. Paul
(Address) 1708 N. Broadway

Filed MAR 30 1927 C. HAMPSON JONES, M. D.
By Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 29th 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec. 25 , 1926 , to Mard 29 , 1927 , that I last saw him alive on Mard 28 , 1927 , and that death occurred, on the date stated above, at 12,30 a.m.

The CAUSE OF DEATH* was as follows:

Myocarditis.
Left Hemiplegia
(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis / Diabetis
(duration) Several yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms.

(Signed) Howard C. Silver, M. D.

, 19 (Address) 3706 Liberty Heights Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| London Park Cemetery | Mar 31st 1927 |
| 20 UNDERTAKER | ADDRESS |
| George Schilling & Sons | 116 E Monument |

Spec.—12-9-25—A Co.—200 Bks.

E 20700

# HEALTH DEPARTMENT—CITY OF BALTIMORE

11-001

## CERTIFICATE OF DEATH.

REGISTERED NO. E 20700

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 913 N. Montford St., 7-13 Ward)

2-FULL NAME Mary Anna Evering

(a) RESIDENCE NO. 913 N. Montford St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 4 1923 Aug 24 1924

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 3 | 7 | 24 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto. (State or country): Md.

PARENTS

10 NAME OF FATHER: Geo. A. Evering

11 BIRTHPLACE OF FATHER (city or town): Balto. (State or country): Md.

12 MAIDEN NAME OF MOTHER: Kath. Kuhn

13 BIRTHPLACE OF MOTHER (city or town): Balto. (State or country): Md.

14 Informant: Geo. A. Evering

(Address): 913 N. Montford

15 Filed 3 30 1927 C. HAMPTON JONES M.D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3-28 19 27

17 I HEREBY CERTIFY, That I attended deceased from 3-20 19 27, to 3-28 19 27

that I last saw h alive on 3-27 19 27

and that death occurred, on the date stated above, at 7:30 A m.

The CAUSE OF DEATH* was as follows: Influenza

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Broncho Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) T. Ford Dunbar M.D.

19 27 (Address) 900 N. Paca St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Date of Burial: March 29/1927

20 UNDERTAKER: Jos. J. Merkabon ADDRESS: 156 N. Luzerne

Spec.-7-17-26—A Co.—200 Blks.

E 20701

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

90 E 20701

REGISTERED NO. 27-43

1-PLACE OF DEATH

City of BALTIMORE: (No. 3 Lorraine Ave Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah E. Collins

(a) RESIDENCE NO. 3 Lorraine Ave Ward

(Usual place of abode)

Length of residence in city or town where death occurred 64 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank C.

6 DATE OF BIRTH (month, day, and year): April 6- 1857

7 AGE: Years 73; Months 7.3 11; Days 23

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 07

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country): Balto

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Balto. Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Germany

14 Informant: Mrs Bertha M. Worden

(Address): 3 Lorraine Ave

15. Filed: MAY 30 1927

C. HAMPSON JONES, M. D. Registrar

By: [illegible]

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 27 1927

17 I HEREBY CERTIFY, That I attended deceased from March 28, 1927, to May 29, 1927,

that I last saw her alive on March 28, 1927,

and that death occurred, on the date stated above, at 4:20 p.m.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted —

If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) Fred J. Kinzer, M. D.

3/29, 1927 (Address) 2700 Hartford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Balto

Date of Burial: 5/31/1927

20 UNDERTAKER: H. M. Cook & Son E. Balto

ADDRESS

Spec.—12-9-25—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

160

E 20702

E 20702

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1412 Argyle Ave St. 14-20 Ward)

2-FULL NAME Baby Summerville

(a) RESIDENCE NO. 1412 Argyle Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: C

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 24 1927

7 AGE — Years | Months | Days: 4 | If LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. City

(State or country)

PARENTS

10 NAME OF FATHER Eddie Summerville

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Anne Arundel Co. Md

12 MAIDEN NAME OF MOTHER Laura Holly

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Anne Arundel Co. Md

14 Informant Laura Summerville

(Address) 1412 Argyle Ave

Filed R30 1927, 19 HAMSON JONES, M. D. Registrar

By

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-28 1927

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....,

that I last saw him alive on March 25, 1927.

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Congenital Debility

(duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. E. McCabe, M. D.

3/29, 1927 (Address) Health Office C.H. 1126 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Ivor — Date of Burial: March 30 1927

20 UNDERTAKER: Joseph A. Lively — ADDRESS: 407 N Mount Street

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 20703
PLACE OF DEATH

E 20703
REGISTERED NO.

City of BALTIMORE: (No. 2533 McCulloh St. 13-59 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank B. Mantley

(a) RESIDENCE NO. 2533 McCulloh St. Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 22-1903

7 AGE: Years 23 Months 11 Days 5 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Dr's
(c) Name of employer

9 BIRTHPLACE (city or town): Md.
(State or country)

PARENTS

10 NAME OF FATHER Frank Mantley

11 BIRTHPLACE OF FATHER (city or town): Va.
(State or country)

12 MAIDEN NAME OF MOTHER Ella Morgan

13 BIRTHPLACE OF MOTHER (city or town):
(State or country) U. S.

14 Informant: Ella Mantley
(Address) 2533 McCulloh

15 Filed 3 30 1927 C. HAMPSON JONES, M. D. Registrar
Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 March 27

17 I HEREBY CERTIFY, That I attended deceased from March 7, 1927, to March 27, 1927, that I last saw h[illegible] alive on March 26, 1927, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) H. McCard, M. D.
3-29, 1927 (Address) Woodbourne Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Date of Burial 3/30 1927

20 UNDERTAKER: Mrs. Geo. H. Holland ADDRESS 1631 Druid Hill Ave.

Spec.–7-17-26—A Co.—200 Bks.

E 20704

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

11-001

E 20704

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2012 Presstman St. 15-21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie E. Hasse

(a) RESIDENCE NO. 2012 Presstman St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 6 mos. 1 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: white

5 ~~Single, Married,~~ Widowed, or ~~Divorced, (write the~~ word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Hasse

6 DATE OF BIRTH (month, day, and year): Sept 16 1847

7 AGE — Years: 79 Months: 6 Days: 12

IF LESS than 1 day ____ hrs. or ____ min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Franz Gunther

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Wilhelmina Fisher

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Neff & Bradburn (Address): 1813 Presstman

APR 30 1927 Filed ____ 19 ____ HAMILTON JONES M. D. Registrar

Per ____

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 28 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 27 1926 to March 28 1927.

that I last saw h. alive on March 27 1927.

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

1 Hemorrhage - pulmonary

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchiectasis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted

if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis? none

(Signed) George Aber Bunbo M. D.

19 (Address) 1517 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemy — Date of Burial: Mar 31 1927

20 UNDERTAKER: Jos Joesdans Son — ADDRESS: 217 S. Pas

Spec.—12-9-25—A Co.—200 Bks.

E 20705

# HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

E 20705

## CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 424 N. Carrollton Ave St. 18-76 Ward)

2-FULL NAME SOPHIA CHRISTINA AIREY

(a) RESIDENCE NO. 424 N. Carrollton Ave St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 3 mos. 9 ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 ~~Single, Married~~, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Philip Airey

6 DATE OF BIRTH (month, day, and year): Dec 7 1850

7 AGE

| Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|
| 76 | 3 | 19 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md

PARENTS

10 NAME OF FATHER: Mentzel

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Unknown

14 Informant: Mrs Kate Pfeffer

(Address) 424 N. Carrollton Ave

15 Filed _____, 19____ _____ Registrar

JAN 30 1927 C. HAMPTON CONN. M.D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 26 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 18th, 1927, to Mar 26th, 1927, that I last saw her alive on Mar 26, 1927, and that death occurred, on the date stated above, at 12 45 P m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) ___ yrs. ___ mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) H. H. Fiscus, M. D.

1/27, 1927 (Address) 3921 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem Date of Burial: Jan 30 1927

20 UNDERTAKER: Jos Joerdens Son ADDRESS: 217 S. Paca

Spec.—1-10-21—M&T—1500 Blks.

E 20706

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

74001 E 20706

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1527 Myrtle Ave 12-40 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary V. Hall

(a) RESIDENCE NO. 1527 Myrtle Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank W. Hall

6 DATE OF BIRTH (month, day, and year) Feb 12. 1862

7 AGE Years 64 Months 6 Days 14 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Westminster Md

PARENTS

10 NAME OF FATHER Amos Bell

11 BIRTHPLACE OF FATHER (city or town) Westminster (State or country) Md

12 MAIDEN NAME OF MOTHER Rebecca Bruce

13 BIRTHPLACE OF MOTHER (city or town) Westminster Md (State or country)

14 Informant Roger Hall

(Address) 1627 Harlem Ave

15 Filed MAR 30 1927 C. HAMPSON JONES, M. D. Registrar

Per RR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 2 1926 to March 26. 1927.

that I last saw h alive on March 25. 1927.

and that death occurred, on the date stated above, at 4.40 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) W. F. Roeiller M. D.

(Address) 1149 Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL Mar 31 1927

20 UNDERTAKER Mrs. P. G. Elliott ADDRESS 1725 Mark Ave

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20707

## CERTIFICATE OF DEATH.

188-002

E 20707

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Sq. Hosp. 8-12 Ward)

2-FULL NAME Geo. J. Havlick

(a) RESIDENCE NO. 2421 E Preston St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs E. V. Havlick

6 DATE OF BIRTH (month, day, and year): Apr 4th 1899

7 AGE — Years: 27 — Months: 11 — Days: 25 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Motorman

(b) General nature of industry, business, or establishment in which employed (or employer): U. R. & E. Co

(c) Name of employer

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER: John Havlick

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Bohemia

12 MAIDEN NAME OF MOTHER: C. Nork

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Bohemia

14 Informant: Mrs E. V. Havlick

(Address) 2421 E Preston St

15 Filed MAR 30 1927 19__ H. M. Lewis M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 29 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry) thereon and from the evidence obtained Investigation (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Both legs Crushed by being Struck by a Street Car Both legs amputated 28 hours

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock

(Duration) yrs. mos. ds.

(Signed) Thos. B. Horton M. D.

(Coroner)

Mch 29th 1927 (Address) Curtis Bay, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Natnre of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cambridge Md Date of Burial 3/31/1927

20 UNDERTAKER: William Cook ADDRESS 502 E North

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20708

## CERTIFICATE OF DEATH.

12 E 20708

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 719 Gold, St. 15-21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Lewis

(a) RESIDENCE NO. 719 Gold ST., ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 14, 1874

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs. or ....min. |
|---|---|---|---|---|
| | 53 | 1 | 14 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steelworker — Ret

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER John Robert Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Sarah Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Sarah Lewis

(Address) 1838 Eutaw St.

15 Filed MAR 30 1927 C. HAMPSON JONES, M.D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan 28, 1927 to March 28, 1927.

that I last saw him alive on March 26, 1927

and that death occurred, on the date stated above, at 12.40 A m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis Chronic

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urine Physical

(Signed) William H Wright M. D.

Mar 28, 1927 (Address) 1209 Pennsylvania

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn DATE OF BURIAL Mar 31 1927

UNDERTAKER Virginia A. Brooks ADDRESS 1463 Carey

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20709

## CERTIFICATE OF DEATH.

REGISTERED E 20709

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2048 Eastern St. 2-4 Ward)

2-FULL NAME Wladyslaw Wojtkowske

(a) RESIDENCE NO. 2048 Eastern St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widower |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) unknown 1879

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 48 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer P. and O. R R Co

9 BIRTHPLACE (city or town)

(State or country) Poland

PARENTS

10 NAME OF FATHER Michial Wojtkowski

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant S. Wojtkowski

(Address) 2048 Eastern Ave.

15 Filed MAR 30 1927 C. HAMILTON JONES, M. D.

Per Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cellulitis

(duration) yrs. mos. 1 ds.

(Signed) G C Jones M. D.

(Coroner)

3/31 1927 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Date of Burial 3/31/ 1927

20 UNDERTAKER W. Gazewski ADDRESS 1930 Eastern Ave

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20710

## CERTIFICATE OF DEATH.

90 E 20710

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) NO. Cecil Apartments ST. N. Eutaw St. WARD)

2-FULL NAME Louisa Lyons Finney

(a) RESIDENCE NO. Cecil Apartments ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George J. Finney

6 DATE OF BIRTH (month, day, and year) Jany 29. 1838

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 89 | 2 | 29 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) D. C.

PARENTS

10 NAME OF FATHER Dr. Augustus Webster

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ann Caldwell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. W. Finney

(Address) 211 Woodlawn Road

15 Filed 0 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 28 1927

17

I HEREBY CERTIFY, That I attended deceased from Mch 26. 1927. to Mch 28. 1927. that I last saw her alive on Mch. 28. 1927. and that death occurred, on the date stated above, at 8.40 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis Myocarditis (Auricular fibrillation) 1 yrs. mos. ds.

Symptoms

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis?

(Signed) Louis P. Hamburger, M. D.

Mch 28. 1927 (Address) 1207 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Churchville Md. Mch 30. 1927

DATE OF BURIAL

20 UNDERTAKER John O. Mitchell

ADDRESS 1900 Eutaw Place

Spec. 12-9-25—A Co.—200 Blks.

Lost

DUPLICATE

E 20711

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31

E 20711

1-PLACE OF DEATH

City of BALTIMORE: (No.) Baltimore City Hospitals (St.) 12-33 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Milton Brown

(a) RESIDENCE NO. 35 E. Hughes st. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | Single |

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1889

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 38 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER John Brown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Caroline ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed MAR 30 1927 E. HAMPSON JONES, M. D. Registrar

per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26, 1927

17

I HEREBY CERTIFY, That I attended deceased from March 17, 1927 to March 26, 1927,

that I last saw him alive on March 26, 1927,

and that death occurred, on the date stated above, at 7.30 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis
Tuberculous enteritis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) W. E. Gatling, M. D.

3-26-27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Cemetery Date of Burial March 30 1927

20 UNDERTAKER R. L. Parham ADDRESS 2120 Harford charged

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20712

## CERTIFICATE OF DEATH.

11-006 E 20712

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1113 E Northern St. 9-18 WARD)

2-FULL NAME Henry A. McMonagle

(a) RESIDENCE NO. 1113 E Northern ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Mr. | W. | Married |

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mary A McMonagle

6 DATE OF BIRTH (month, day, and year) Dec 8/70

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or ... min. |
|---|---|---|---|---|
| | 56 | 3 | 20 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) Mattress Factory

(c) Name of employer R. C. Hilberg Co Philadelphia Pa

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Henry McMonagle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Sarah Dupenia

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

### MEDICAL CERTIFICATE OF DEATH.

16 DATE OF DEATH (month, day, and year) 3/28 1927

17

I HEREBY CERTIFY, That I attended deceased from March 22, 1927, to March 28, 1927.

that I last saw h[illegible] alive on March 28, 1927.

and that death occurred, on the date stated above, at 3.25 P. m.

The CAUSE OF DEATH* was as follows:

Influenzal Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted, if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Hyde, M. D.

3/30, 1927 (Address) 1600 E Northern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

14 Informant Mary A McMonagle

(Address) 1113 E Northern

Filed MAR 30 1927, 19 C. HAMPSON JONES, M. D.

Registrar

Per [illegible]

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem.

DATE OF BURIAL 3/29 1927

20 UNDERTAKER Mary M. Niedefeld.

ADDRESS 504 E 22

pec.—1-12-23—M&T—500 Blks.

E 20713 HEALTH DEPARTMENT—CITY OF BALTIMORE E 20713

46

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Joseph's Hospital.

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Caroline & Oliver ST. 7-4 WARD)

2-FULL NAME Rose Lewandowski

(a) RESIDENCE NO. 1721 Gough ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | white | married (separated) |

6 If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) Aug 21 - 1877

| AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 38 | 7 | 7 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar-Roller. 017

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore, Md.

10 NAME OF FATHER Joseph Stacharowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Lena Plachaski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

Informant Mrs. Rose Szczepaniak (sister)

(Address) 1735 Monroe St.

Filed MAR 30 1927 C. HAMPSON JONES, M. D. Registrar

Per

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28 1927

I HEREBY CERTIFY, That I attended deceased from Feb. 21, 1927, to March 28, 1927, that I last saw her alive on March 28, 1927, and that death occurred, on the date stated above, at 5:35 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of ovary - (Left

Generalized Carcinamitosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? no Date of ——

Was there an autopsy? yes.

What test confirmed diagnosis? Clinical & ↻

(Signed) H. R. Wemmell, M. D.

, 19 (Address) St. Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus. Cem. DATE OF BURIAL Mar 31, 1927

20 UNDERTAKER F. Sadowski ADDRESS 735 Hanover

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20714

## CERTIFICATE OF DEATH.

90

REGISTERED NO. E 20714

1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore General Hospital 3-31-27

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nicholas H. Kemp.

(a) RESIDENCE NO. 3855 Quarry Ave St. Ward Baltimore

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widowed |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) November 3rd 1854

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 72 | 4 | 25 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk (of)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Wilbur H. Kemp

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Harriet T. Bull

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland.

14 Informant Clarence Kemp.

(Address) 3855 Quarry Ave.

Filed C. HAMPSON JONES, M. D.

0 1927 Per R.E.H. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28th 1927. 19

17

I HEREBY CERTIFY, That I attended deceased from Feb 28th, 1927, to March 28th, 1927, that I last saw h in alive on March 28th, 1927, and that death occurred, on the date stated above, at 5:25 P.m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilation

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) yrs. mos. 28 ds.

over

18 Where was disease contracted

If not at place of death? At Home.

Did an operation precede death? Yes Date of Mar. 25th, 27.

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) H. L. Miller, M. D.

, 19 (Address) 1 Bell Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Marys Hampden Date of Burial: March 31, 27.

20 UNDERTAKER: Chenoweth & Son ADDRESS: 3616 Chestnut Ave.

Spec. 7-17-26 A.C. 200 Bks.

E 20715

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

31 E 20715

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3405 Chestnut Ave. St. 13-52 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William R. Mc Clure

(a) RESIDENCE NO. 3405 Chestnut Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7/12 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of: ✓ ✓

6 DATE OF BIRTH (month, day, and year): May 30, 1906

7 AGE: Years 20 Months 9 Days 29 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: minister

(b) General nature of industry, business, or establishment in which employed (or employer): M.E.

(c) Name of employer

9 BIRTHPLACE (city or town): Md.

(State or country)

PARENTS

10 NAME OF FATHER: Wm. W. Mc Clure

11 BIRTHPLACE OF FATHER (City or town): Md.

(State or country)

12 MAIDEN NAME OF MOTHER: Annie E. Mc Clure

13 BIRTHPLACE OF MOTHER (city or town): Md.

(State or country)

14 Informant: William W. Mc Clure

(Address): 3405 Chestnut Ave

15 Filed: APR 1 1927 C. HAMPSON JONES, M. D. Registrar

Per: [illegible]

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 29, 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1926, to Mch. 29, 1927

that I last saw him alive on Mch. 29, 1927

and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Same

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical History & Symptoms

(Signed) Edwin F. Kelly, M. D.

(Address) 1 Scarborough Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — Date of Burial: Apl 1 1927

20 UNDERTAKER: Chenowith Son — ADDRESS: 3617 Chestnut Ave

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20716

## CERTIFICATE OF DEATH.

#6 E 20716

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1737 Harford Ave ST. 9-17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosanna L. Foster

(a) RESIDENCE No. 1737 Harford Ave ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of: William Foster

DATE OF BIRTH (month, day, and year): May. 15. 1855

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| 71 | | 10 | 12 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework 37

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

BIRTHPLACE (city or town) (State or country): Sudbury. Pa.

10 NAME OF FATHER: Jacob Cable.

11 BIRTHPLACE OF FATHER (city or town) (State or country): England.

12 MAIDEN NAME OF MOTHER: Maria A. Klinefelter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Sudbury Pa.

14 Informant: Mary E. Hoffman.
(Address) 1737 Harford Ave

15 1927 C. HAMPSON JONES, M. D. Registrar.
Per RRR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 27, 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 25. 1926. to March 27. 1927.

that I last saw her alive on March 26. 1927.

and that death occurred, on the date stated above, at 6,30 P m.

The CAUSE OF DEATH* was as follows:

Cancer of uterus

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Ervin F. Zimmerman M.D.

(Address) 1-1708 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Glenwood Pa. Pen County — DATE OF BURIAL: March 31 1927

20 UNDERTAKER: Geo. F. Ruth, 1735 Harford — ADDRESS

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20717.

## CERTIFICATE OF DEATH.

161-001

E 20717

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 421 Lewis ST. 5-8 WARD)

2-FULL NAME Baby Smith

(a) RESIDENCE NO. 421 Lewis ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | Col | Single |

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 28-1927

7 AGE

| Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|
| | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

10 NAME OF FATHER Lucas Smith

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore

12 MAIDEN NAME OF MOTHER Geneva Smith

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore

14 Informant Geneva Smith
(Address) 421 Lewis

15 Filed 19 C. HAMPSON JONES, M. D.
Registrar

0 1927 Per 219

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29 19 27

17

I HEREBY CERTIFY, That I attended deceased from March 28, 19 27, to March 29, 19 27, that I last saw h alive on March 28, 19 27, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Accident to pregnancy
Premature birth of
about 7 Months (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mother sick with
Coma (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W Clyde Barnes, M. D.

3-29 19 27 (Address) 417 E 32

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND — DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health. — ADDRESS

MAR 30 1927

Spec.—1-10-21—M&T—1500 Bks.

20718

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20718

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Maryland General Hospital REGISTERED NO. 117

CITY OF BALTIMORE: (No.) ..... St. 16-67 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gay Roane

(a) RESIDENCE NO. 601 Lennard ..... ST., ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Iris Roane.

6 DATE OF BIRTH (month, day, and year) 8/25/87

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 39 | 7 | 4 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dairy Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) East Va.

PARENTS

10 NAME OF FATHER H H Roane.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mamie Gay

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records.

(Address)

FILED 1927 C. HAMPSON JONES, M. D. Registrar

Per .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/29 1927

17 I HEREBY CERTIFY, That I attended deceased from 3/9 1927, to 3/29 1927.

that I last saw him alive on 3/29 1927.

and that death occurred, on the date stated above, at 8:30 a. m.

The CAUSE OF DEATH* was as follows:

Gastric ulcer

Chronic appendicitis

(duration) 15 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Coronary Thrombosis

(duration) ..... yrs. ..... mos. 1 ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 3/24/27

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) C C Zellmanowitz, M. D.

, 19 (Address) Md Gen'l Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL West Point Va. DATE OF BURIAL Apl 2 1927

20 UNDERTAKER Harry H Amuscos Ridgewood Ave ADDRESS

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20719

E 20719

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

REGISTERED NO.

City of BALTIMORE: (No. [redacted] St., 16-37 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Johnson

(a) RESIDENCE NO. BALTIMORE CITY HOSPITALS Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. 9 mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Divorced |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1898

| 7 AGE | Years | Months | Days | IF LESS than I day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 29 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Graduate Nurse

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer BALTIMORE CITY HOSPITALS

9 BIRTHPLACE (city or town)

(State or country) England

PARENTS

10 NAME OF FATHER Peter Baker

11 BIRTHPLACE OF FATHER (city or town)

(State or country) England

12 MAIDEN NAME OF MOTHER Mary —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) England

14 Informant BALTIMORE CITY HOSPITALS

(Address) Records

15 Filed 1927 C. HAMPSON JONES, M. D.

By RRA Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29 1927

17

I HEREBY CERTIFY, That I attended deceased from November 18, 1926, to March 29, 1927, that I last saw h[illegible] alive on March 29, 1927, and that death occurred, on the date stated above, at 5 10 P m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency, Rheumatic
Mitral Stenosis & Insufficiency
Myocardial Insufficiency

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Infarction

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? gen'l & laboratory

(Signed) R Hoopes Smith, M. D.

Mch 29 1927 Address BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Anderson S.C. Mch 30 1927

20 UNDERTAKER ADDRESS

John O. Mitchell Eutaw Place

Spec.—1-10-21—M&T—1500 Bks.

E 20720

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20720

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Volunteers of America Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 418 W Lexington ST. 15-67 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Ward

(a) RESIDENCE No. 2929 W. North Ave. ST., ..... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widower |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mollie Ridgly Ward

6 DATE OF BIRTH (month, day, and year) July 1863

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 63 | 8 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Produce dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER George Ward

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Susan Richards

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Elizabeth Ward

(Address) 2929 W. North Ave.

15 1927 C. HAMPSON JONES, M. D.

Per ..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30 1927

17 I HEREBY CERTIFY, That I attended deceased from March 7 1927 to March 30 1927.

that I last saw him alive on March 30 1927.

and that death occurred, on the date stated above, at 8.30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 2 yrs. mos — ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Karl J. Steinmueller M. D.

(Address) 327 N. Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Druid Ridge Cemy, | April 1, 1927 |
| 20 UNDERTAKER | ADDRESS |
| John O. Mitchell | 1900 Eutaw Pl. |

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20721

## CERTIFICATE OF DEATH.

E 20721

REGISTERED NO._____

(If death occurred in a hospitnl or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. City Jail St. 11-15 Ward)

2-FULL NAME Robert Chetney

(a) RESIDENCE NO. 717 St Paul + $160 maine an- St. Buffalo N.Y. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | white | Divorced |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Roe Brown

6 DATE OF BIRTH (month, day, and year) Nov 13 1880

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 46 | 4 | 17 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Corning N.Y.

(State or country)

PARENTS

10 NAME OF FATHER Alvin Chetney

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Corning N.Y.

12 MAIDEN NAME OF MOTHER Ella Burk

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Corning N.Y.

14 Informant Henry Sauerbrun

(Address) Buffalo N.Y.

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

Hanging (duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Barbiturate Poisoning (duration) .....yrs. .....

(Signed) .....(Coroner) M. D.

March 30, 1927 Address Hurley

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Buffalo N.Y. Date of Burial Mar 31st 27

20 UNDERTAKER C. F. Barton Address Northern Parkway

Spec.—1-10-21—M&T—1500 Bks.

20722

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

89 E 20722
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 18 N. Amity ST. 18-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nathan Portney

(a) RESIDENCE NO. 18 N. Amity ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced: Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary Portney

6 DATE OF BIRTH (month, day, and year) April 10 18[illegible]

7 AGE: Years 45 Months 11 Days 20 If LESS than 1 day, ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Merchant
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS
10 NAME OF FATHER Sam Portney
11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia
12 MAIDEN NAME OF MOTHER Mary —
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Mary Portney
(Address): 18 N. Amity St

15 Filed MAR 31 1927
HAMPSON JONES, M. D.
Registrar
Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-30-1927

17 I HEREBY CERTIFY, That I attended deceased from March 30, 1927, to March 30, 1927, that I last saw him alive on March 30, 1927 and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Gastritis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

3/31, 1927 (Address) 210 S. Spring

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Int. Council — DATE OF BURIAL: 3/31 1927

20 UNDERTAKER: Jack Levis — ADDRESS: 1439 E. Baltimore St

Spec.—1-10-21—M&T—1500 Bks.

Ê 20723

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

Ê 20723

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md General Hospital St. 16-22 90 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Usadc Friedman

(a) RESIDENCE No. 825 Appleton St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W. | Manid |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Friedman

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 53 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocer

(b) General nature of industry, business, or establishment in which employed (or employer) Grocery

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Jenet Friedman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rose Bontz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Hospital Records (Address)

15 Filed 3 1 1927, 19 HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-30 1927

17

I HEREBY CERTIFY, That I attended deceased from March 25, 1927, to March 30, 1927, that I last saw h[illegible]ive on March 30, 1927, and that death occurred, on the date stated above, at 3 30 P. m.

The CAUSE OF DEATH* was as follows:

Cachio Pneumonia Duriano

Myocarditis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Congestion 1 day

Cardiac mitral dilatation.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinick

(Signed) [illegible] M. D.

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Int Carmel

DATE OF BURIAL 3/31 1927

20 UNDERTAKER Jack Levis 1439 E Balt St

ADDRESS

Spec.—1-12-23—M&T—500 Bks.

Frances Horky

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20724

E 20724

## CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 705 N Collington ST., 7-12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Horsky

(a) RESIDENCE No. 705 N Collington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: John Horsky

DATE OF BIRTH (month, day, and year): 1874

| AGE | Years | Months | Days | If LESS than 1 day, ..... hrs or ..... min. |
|---|---|---|---|---|
| | 53 | | | |

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Bohemia

10 NAME OF FATHER: John Porpiec

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Barbara Smerad

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

14 Informant: John Horsky

(Address): 705 N Collington

15 Filed MAR 1 1927, 19 C. HAMPSON JONES, M. D. Registrar

Per RM

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3-29 1927

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1927 to March 29 1927

that I last saw her alive on 3-22 1927

and that death occurred, on the date stated above, at 6 00 M

The CAUSE OF DEATH was as follows:

Cerebral Hemorrhage

Complete Hemiplegia

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Fred Zapffe M. D.

(Address) 500 N Broadway 3-31 1927

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer

DATE OF BURIAL: April 2 1927

20 UNDERTAKER: Edward Crockton

ADDRESS: 1916 E Lanvale

Spec.—1-12-23—M&T—500 Bks.

Loretta Poledna

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20725 — 9-E 20725

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2003 E Federal ST. 8-17 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Loretta Poledna

(a) RESIDENCE NO. 2003 E Federal ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Aug 20 1925

| AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 1 | 9 | 10 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Balto

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not known

12 MAIDEN NAME OF MOTHER: "

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

PARENTS

14 Informant: Mrs. Anna Poledna

(Address) 2003 E. Federal St.

15 Filed Jan 31 1927, 19 Per C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-30 27

17 I HEREBY CERTIFY, That I attended deceased from 3-25, 1927 to 3-30, 1927 that I last saw h[illegible] alive on 3-22, 1927 and that death occurred, on the date stated above, at 4:10 P.M.

The CAUSE OF DEATH* was as follows: [redacted] Pertussis

(duration) yrs. mos 1 ds. 4

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) Floyd Rupert M. D.

3-30, 1927 (Address) 800 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Mar 31 1927

20 UNDERTAKER: Frank Crockson — ADDRESS: 1906 Orlow

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20726

## CERTIFICATE OF DEATH.

124 E 20726

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3234 Trident ST. 10th WARD)

2-FULL NAME George Kimmel

(a) RESIDENCE NO. 3234 Trident ST. 1st WARD

(Usual place of abode)

Length of residence in city or town where death occurred 77 yrs. 5 mos. 28 ds. How long in U. S., if of foreign birth? ✓ yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Catherine E. Kimmel

6 DATE OF BIRTH (month, day, and year): Oct 1st 1849

7 AGE — Years: 77 — Months: 5 — Days: 28 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Barber

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Jacob Kimmel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Margaret Snyder

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Catherine E. Kimmel (Address) 3234 Trident ST.

15 Filed MAR 31 1927 19 C. HAMPSON JONES, M. D. Registrar Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 24 1927

17

I HEREBY CERTIFY, That I attended deceased from March 10, 1927, to March 24, 1927.

That I last saw him alive on March 24, 1927,

and that death occurred, on the date stated above, at 10 45 m.

The CAUSE OF DEATH* was as follows:

Chr Interstitial Nephritis

Endocarditis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Norris E. Mitchell, M. D.

1927 (Address) 2151 Fillmore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: March 31 1927

20 UNDERTAKER: F. B. Wisepart

ADDRESS: 1650 W. Baltimore St

Spec.—5-19-13—M. & T.—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20727

## CERTIFICATE OF DEATH.

90 E 20727

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 733 W. Mulberry St 4th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Snowden Duckett

(Residence in Baltimore: No. 733 W. Mulberry St St.; yrs. mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

| 3-SEX. | 4-COLOR OR RACE. | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) |
|---|---|---|
| M | Col | Single |

6-DATE OF BIRTH, January (Month) 28 (Day), 1888 (Year)

7-AGE, 39 yrs. 2 mos. 2 ds. If LESS than 1 day, ....hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Minister
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. George F Duckett

11-BIRTHPLACE OF FATHER (State or Country). Baltimore Md

12-MAIDEN NAME OF MOTHER Annie Lane

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John H Duckett

(Address) 733 W Mulberry St

15- Filed 3-1 1927 C. HAMPSON JONES, M. D. Per ..... 191 ..... Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 30 (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar 24 1927, to Mar 30 1927, that I saw him alive on Mar 30 1927, and that death occurred, on the date stated above, at 3.05 A m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthenia

(Duration) 0 yrs. 0 mos. 4 ds.

CONTRIBUTORY (Secondary) Valvular Heart disease

(Duration) 9 yrs. 5 mos. 28 ds.

(Signed) John Lee Lansburg M. D.

Mar 30 1927 (Address) 103 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem DATE OF BURIAL, ..... 191...

20-UNDERTAKER Emmert Bros ADDRESS W Balto

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20728
1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

425

E 20728
REGISTERED NO.

City of BALTIMORE: (No.) Baltimore City Hospitals St. (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Aquilla

(a) RESIDENCE NO. 222 N. Green st. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? Unknown yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ROSA AQUILA

6 DATE OF BIRTH (month, day, and year) July 24. 1892

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 35 | 8 | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fruit dealer

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Italy

PARENTS

10 NAME OF FATHER Tony Aquilla

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Italy

12 MAIDEN NAME OF MOTHER Angler Aquilla

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Italy

14 Informant (Address) John Aquila 222 N. Greene St.

Filed 3 1 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from January 7 19 27, to March 30, 19 27,

that I last saw him alive on March 30, 19 27,

and that death occurred, on the date stated above, at 6.45 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted Unknown

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings.

(Signed) W. E. Gallant, M. D.

3-30-27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL new. Cathedral Cemetery Date of Burial 4/1 1927

20 UNDERTAKER George J Ruth ADDRESS 1735 Harford ave

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20729

## CERTIFICATE OF DEATH.

185 E 20729

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Salto City Hospital St. 24-34 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Fitzpatrick

(a) RESIDENCE NO. 115 E Barney St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | white | widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Fitzpatrick

6 DATE OF BIRTH (month, day, and year) July 2. 1875

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or....min. |
|---|---|---|---|---|
| | 51 | 8 | 21 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Yorkm Md RR

9 BIRTHPLACE (city or town)

(State or country) Galto Md.

PARENTS

10 NAME OF FATHER John Fitzpatrick

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Mahoney

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Katie Mooney

(Address) 115 E Barney St

Filed 1927 C. HAMPTON JONES, M. D.

R31 1527 Per RK Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 27 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said X Ray (Inquest, autopsy or inquiry.) report find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows: Fracture 4th D Cervical Vertebrae in fall down Stairs at his home accident

(duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) ....yrs. ....mos. ....ds.

(Signed) James M Fenton M. D.

(Coroner)

3-30 1927 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ....yrs. ....mos. 9 wds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

110 E Barney

Former or usual residence 115 E Barney

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Date of Burial April 6 1927

20 UNDERTAKER Wm Cook ADDRESS 502 E Biddle

Spec.—12-9-25—A Co.—200 Bks.

Melanie Profilet

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20730
1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

+ 84

E 20730
REGISTERED NO.

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Melanie Profilet

(a) RESIDENCE NO. Natchez Miss St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, ~~Married,~~ ~~Widowed,~~ or ~~Divorced~~ (write the word): Single

5a If ~~married, widowed, or divorced~~ HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6-28-24

7 AGE: Years 4 | Months 9 | Days 2 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Girl

(b) General nature of industry, business, or establishment in which employed (or employer): 600

(c) Name of employer

9 BIRTHPLACE (City or town) Natchez

(State or country) Miss

PARENTS

10 NAME OF FATHER Clarence Profilet

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Miss -

12 MAIDEN NAME OF MOTHER Alice Grady

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) La.

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed MAR 31 1927 19 C. HAMPSON JONES, M.D. Registrar

Per R.M.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 30 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar. 29, 1927, to Mar. 30, 1927, that I last saw h.. alive on March 30th, 1927, and that death occurred, on the date stated above, at 6 00 P m.

The CAUSE OF DEATH* was as follows:

Brain Tumor - glioma (Cerebellum)

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3/30/27

Was there an autopsy? Yes

What test confirmed diagnosis? Operation and autopsy

(Signed) George G. Finney M.D.

3/30/27 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Natchez Miss. Date of Burial: March 31 1927

20 UNDERTAKER: Henry H. Jakes & Son ADDRESS: Cedar & Mc Colloh St

pec.—1-12-23—M&T—500 Bks.

# E 20731 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31

E 20731
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 900 Shuter ST., 7-13 WARD)

2-FULL NAME James Hill

(a) RESIDENCE NO. 900 Shuter ST. WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | C | S |

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) April 10, 1910

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min |
|---|---|---|---|---|
| | 16 | 11 | 18 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work student pd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Charles H. Hill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Hattie Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Richmond Virginia

14 Informant Chas. Hill
(Address) 900 Shuter

Filed MAR 31 1927 19

C. HAMPSON JONES, M. D.
Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3. 28 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 14. 1927. to Mar 28. 1927.

that I last saw h alive on March 28. 1927.

and that death occurred, on the date stated above, at 12:25 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exp Ha

(Signed) W. H. Berry, M. D.

, 19 (Address) 1520 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Henry Cemetery | Mar 31 1927 |
| 20 UNDERTAKER Mrs. R. G. Elliott | ADDRESS 725 Ashland Av |

MAR 31 1927

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 20732

## CERTIFICATE OF DEATH

E 20732

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 739 N. Woodland Ave. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Mason Gardner

(a) RESIDENCE NO. 739 N. Woodland Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~xxx~~ mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec. 29 1922

7 AGE: Years 4 Months 3 Days 1

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Paul A. Gardner

11 BIRTHPLACE OF FATHER (City or town) Tilsit

(State or country) Russia

12 MAIDEN NAME OF MOTHER Blanche E. Mason

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Md.

14 Informant Paul A. Gardner

(Address) 739 N. Woodland Ave.

Filed MAR 31 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29th 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar. 27, 1927, to Mar. 29, 1927, that I last saw h~~im~~ alive on Mar. 28, 1927, and that death occurred, on the date stated above, at 6 30 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings.

(Signed) John A. Brothers, M. D.

3/29, 1927 (Address) 37 So. Hacker St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem.

Date of Burial: Mar 31st 1927

20 UNDERTAKER: Joseph F. Cook

ADDRESS: 1003 N. Gay St.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20733

## CERTIFICATE OF DEATH

E 20733

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1326 N. Chester St. 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cdas C. Norwood

(a) RESIDENCE NO. 1326 N. Chester St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred / yrs. 3 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward M. Norwood

6 DATE OF BIRTH (month, day, and year) April 21 1855

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min.. |
|---|---|---|---|---|
| | 71 | 11 | 8 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Co.

(State or country) Maryland

PARENTS

10 NAME OF FATHER Michael Cline

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Eliz. Louise Berry

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Edward M. Norwood

(Address) 1326 N. Chester St.

15 Filed ....., 19 ..... Registrar

MAR 31 1927 C. HAMPSON JONES, M. D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29th 19 27

17 I HEREBY CERTIFY, That I attended deceased from Mar 3, 1927, to Mar 29, 1927, that I last saw h alive on March 29, 1927, and that death occurred, on the date stated above, at 2.10 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 5 ds.

CONTRIBUTORY Arteriosclerosis

(Secondary)

(duration) yrs. mos 25 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

I (Signed) John W. Davidson, M. D.

30, 1927 (Address) 1714 N Leander St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem. — Date of Burial Mar 31 1927

20 UNDERTAKER Joseph B. Cook — ADDRESS 1003 W. Balto St.

Spec—12-23-21—E.B.R.S.—400 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 20734 — 90 E 20734

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: No. 1628 Madison Ave (St.) Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Blake

(a) Residence No. 1628 Madison Ave (Usual place of abode) Ward

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Widower

6-DATE OF BIRTH (month, day and year)

7-AGE, 45 and odd yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) General

(c) Name of employer Not known

9-BIRTHPLACE (city or town) Baltimore (State or Country),

PARENTS.

10-NAME OF FATHER, Frirby Blake

11-BIRTHPLACE OF FATHER (city or town) Md. (State or Country),

12-MAIDEN NAME OF MOTHER Josephine Hoffstetter

13-BIRTHPLACE OF MOTHER (city or town) Md (State or Country),

14- (Informant) Gertrude Hopkins (Address) 1628 Madison Ave

15- C. HAMPSON JONES, M. D. MAR 31 1927 192 Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Mar 27, 1927

17- I HEREBY CERTIFY, That I attended deceased from Jan 3, 1927 to March 27 1927 that I last saw him alive on March 26, 1927 and that death occurred, on the date stated above, at 8P m.

The CAUSE OF DEATH* was as follows: Endocarditis

(Duration) 3 mos.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. D. Stewart M. D.

, 19 (Address) 704 W Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt Auburn Cy — DATE OF BURIAL, 3/31/27

20-UNDERTAKER, Leonard Wade — ADDRESS, 704 Lafayette Ave

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20735

## CERTIFICATE OF DEATH.

21

E 20735

REGISTERED NO.

1-PLACE OF DEATH Balto City Hospts

City of BALTIMORE: (No. Balto Md St. 9-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Williams

(a) RESIDENCE NO. 502 E 28th St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. dy. How long in U. S., if of foreign birth? yrs. mos. dy.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Florence Williams

6 DATE OF BIRTH (month, day, and year): 6-18-1876

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 50 | 9 | 12 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work:

(b) General nature of industry, business, or establishment in which employed (or employer): Slater

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country) Maryland

PARENTS

10 NAME OF FATHER John H. Williams

11 BIRTHPLACE OF FATHER (city or town):

(State or country) N.Y. State

12 MAIDEN NAME OF MOTHER Amelia Henry

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Maryland

14 Informant (Address) Balto City Hospt Balto Md

15 Filed ....., 19.....

C. HAMPSON JONES, M. D.

Registrar

3 1 1927

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

3-30 27

17 I HEREBY CERTIFY, That I attended deceased from 3-9, 19 27, to 3-30, 19 27

that I last saw h[illegible] alive on 3-30, 19 27

and that death occurred, on the date stated above, at 4.30 P. m.

THE CAUSE OF DEATH* was as follows:

Terminal Broncho Pneumonia

Toxoplasmosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Alcoholic Psychosis - Korsakoffs Syndrome

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical findings

(Signed) Harry Friedenwald M. D.

, 19 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: State Ridge Pa

Date of Burial: 4/2 1927

20 UNDERTAKER: William Cook

ADDRESS: 502 E. North

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20736

## CERTIFICATE OF DEATH.

90 E 20736

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

REGISTERED NO.

City of BALTIMORE: (No. [redacted] Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James McConnell

(a) RESIDENCE NO. 1830 E. Madison St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| White | White | ? |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Teresa McConnell

6 DATE OF BIRTH (month, day, and year) 1885

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 42 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Ireland

PARENTS

10 NAME OF FATHER Peter McConnell

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Anne Adams

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant

(Address) BALTIMORE CITY HOSPITALS

Filed ..... 19 .....

Per ..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30 1927.

17

I HEREBY CERTIFY, That I attended deceased from March 7, 19 27, to March 30, 19 27, that I last saw h. alive on March 30, 19 27, and that death occurred, on the date stated above, at 4:10 A. m.

The CAUSE OF DEATH* was as follows:

myocarditis, chronic & acute

Adams disease

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? General & Gross

(Signed) C. Adams Bond M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem. Date of Burial 4/2 1927.

20 UNDERTAKER W. P. Cook. ADDRESS 502 E North ave.

BALTIMORE CITY HOSPITALS

1927 C. HARRISON JONES, M. D.

Filed ..... 19 .....

Per ..... Registrar

Spec.—12-9-25—A Co.—200 Bks.

20995

E 20737

1-PLACE OF DEATH

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

X 84

REGISTERED NO. E 20737

City of BALTIMORE: (No. JOHNS HOPKINS HOSP. St., 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raymond Thompson

(a) RESIDENCE NO. Salem Md — St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 14 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | Married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 29 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md —

(State or country)

PARENTS

10 NAME OF FATHER C

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER Estella

13 BIRTHPLACE OF MOTHER (city or town) Md —

(State or country)

14 Informant Peoples —

(Address) JOHNS HOPKINS HOSP

15 Filed MAR 31 1927, 19 C. HAMPSON JONES, M. D. Registrar

Per _____

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 28 1927

17

I HEREBY CERTIFY, That I attended deceased from Mar 10, 1927, to Mar 30, 1927, that I last saw him alive on Mar 28, 1927, and that death occurred, on the date stated above, at 5:50 a. m.

The CAUSE OF DEATH* was as follows:

Brain tumor - Glioma - (Benign)

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of 3/21/27

Was there an autopsy? Yes

What test confirmed diagnosis? Operation and Autopsy

(Signed) George E. Tinney, M. D.

3/30/27 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cambridge, Md. Date of Burial Mar 31 1927

20 UNDERTAKER Jno. M. Johnson ADDRESS 1232 E Chase St

Spec.-7-17-26—A Co.—200 Bks.

E 20738

# HEALTH DEPARTMENT—CITY OF BALTIMORE

86-001

E 20738

## CERTIFICATE OF DEATH

1-PLACE OF DEATH Union Memorial Hospital REGISTERED NO.

City of BALTIMORE: (No. 33rd & Calvert St St. 12-44 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Ann Offutt

(a) RESIDENCE NO. 2025 Balto Ave Towson Md St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) September 30, 1925

7 AGE: Years 1 Months 6 Days 1 IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland (State or country)

PARENTS

10 NAME OF FATHER J. Frederick Offutt

11 BIRTHPLACE OF FATHER (City or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Virginia Trumbull

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Hospital Records (Address)

15 Filed MAR 31 1927 19 G. HAMBLOCK JONES, M. D. Registrar

by R.H.C.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from March 26, 1927 to March 31, 1927, that I last saw her alive on March 31, 1927, and that death occurred, on the date stated above, at 11:20 A m.

The CAUSE OF DEATH* was as follows:

Otitis media bilateral

(duration) yrs. mos. 19 ds.

CONTRIBUTORY (Secondary) Septicemia, hemolytic streptococcal

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? clinical + laboratory methods

(Signed) Frank R Smith, Jr., M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sherwood Cemetery Cockeysville Md. Date of Burial Apr. 2 1927

20 UNDERTAKER: H W Mears ADDRESS 3 Low 705 N Calvert St

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20739

## CERTIFICATE OF DEATH.

11-00

E 20739

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1415 Jefferson ST. 5-9 (WARD)

2-FULL NAME George E. Anderson

(a) RESIDENCE No. 1415 Jefferson ST., WARD ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred XX yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Infant

If married, widowed, or divorced HUSBAND of (or) WIFE of: (Infant)

DATE OF BIRTH (month, day, and year): Feb. 22, 1926

AGE: Years 1 Months 1 Days 8 If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ✓

(b) General nature of industry, business, or establishment in which employed (or employer): ✓ 800

(c) Name of employer: ✓

BIRTHPLACE (city or town) (State or country): Atlantic City, N.J.

10 NAME OF FATHER: Harry Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto, Md

12 MAIDEN NAME OF MOTHER: Beatrice Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

Informant (Address): Harry Anderson, 1415 Jefferson St

Filed 3 1927 19 Per ... C. HAMPTON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/30 1927

17 I HEREBY CERTIFY, That I attended deceased from 3/27, 1927, to 3/30, 1927, that I last saw h[illegible] alive on 3/30, 1927, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction
and Influenza

(duration) ... yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary): Rickets

(duration) ... yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? ✓

What test confirmed diagnosis? Signs & Symptoms

(Signed) Jas. R. Blake M.D.

3/31, 19 (Address) 1402 Jefferson St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery

DATE OF BURIAL: April 1 1927

20 UNDERTAKER: Joe T. H. Rochester

ADDRESS: 1413 Jefferson st

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20740

E 20740

## CERTIFICATE OF DEATH.

REGISTERED NO. 161

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 405 W 25 ST., 12-51 WARD)

2-FULL NAME Joseph Baker

(a) RESIDENCE NO. 405 W 25 ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 hrs. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Christopher Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Cumberland Md.

12 MAIDEN NAME OF MOTHER: Erma Reich

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pittsburg Pa

14 Informant: Erma Baker

(Address): 405 W 25 St.

15 Filed: 1 1927 C. HAMPSON JONES, M. D. Registrar

P. 213

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 30 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 27. 1927. to Mar 30. 1927.

that I last saw h alive on Mar 27. 1927.

and that death occurred, on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Premature birth

Two months uterine

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Lorenz Strauss M. D.

Mar 30. 1927 (Address) 1438 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL. 19

20 UNDERTAKER ADDRESS

Commissioner Health

MAR 31 1927

UNIVERSITY OF MARYLAND

For C. E. TOWNSEND

Spec.—12-9-25—A Co.—200 Bks.

E 20741

# HEALTH DEPARTMENT—CITY OF BALTIMORE

31 E 20741

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. 27-31 Ward)

2-FULL NAME William Woodley

(a) RESIDENCE NO. 424 Henrietta st. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | Single |

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1895

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 32 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER Sam. Woodley

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Susie Wilkins

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant Hospital Records

(Address) (UNIVERSITY OF MARYLAND)

15 Filed MAR 31 1927 19 C. HAMPSON JONES, M. D. Registrar

Per 1214 RTH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27. 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Jan. 11 19 27 to March 27 19 27

that I last saw him alive on March 27 19 27

and that death occurred, on the date stated above, at 9.15 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. E. Gatling, M. D.

3-27-27 19 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial MAR 31 1927 19

20 UNDERTAKER

ADDRESS

C. HAMPSON JONES, M. D.
Commissioner of Health

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20742

CERTIFICATE OF DEATH.

1037 100-001

E 20742

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. ____ St. ____ Ward)

REGISTERED NO. ____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Mc Abee

(a) RESIDENCE NO. 2911 Ave B. Ensley Ala St. ____ Ward ____

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1891

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 36 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) ____

(State or country) Alabama

PARENTS

10 NAME OF FATHER William McAbee

11 BIRTHPLACE OF FATHER (city or town) ____

(State or country) Georgia

12 MAIDEN NAME OF MOTHER Sally —

13 BIRTHPLACE OF MOTHER (city or town) ____

(State or country) Georgia

14 Informant ____

(Address) Records

15 Filed ____ ____ Registrar

AKK 1215

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 1927

17

I HEREBY CERTIFY, That I attended deceased from March 23 1927, to March 25, 1927, that I last saw him alive on March 24, 1927, and that death occurred, on the date stated above, at 6 45 Am.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ____ yrs. ____ mos. 5 ds.

CONTRIBUTORY (Secondary) Myocardial Jenture

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? ____

Did an operation precede death? no Date of ____

Was there an autopsy? no

What test confirmed diagnosis? Laboratory

(Signed) R. Hooper Smith, M. D.

March 30 27 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Interred and buried Ensley Alabama DATE 4-2-27

20 UNDERTAKER ADDRESS

Tom Cook 502 E North Ave

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20743

## CERTIFICATE OF DEATH.

38 E 20743

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Balt City Hospital St. 27-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sylvester Bowen

(a) RESIDENCE NO. 211 Wylie Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 25 | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Labors

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Jamaica

(State or country)

PARENTS

10 NAME OF FATHER Joseph Bowen

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Jamaica

12 MAIDEN NAME OF MOTHER Catherine Rose

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Jamaica

14 Informant

(Address)

19

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27, 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 28, 1927, to March 27, 1927

that I last saw him alive on March 27, 1927,

and that death occurred, on the date stated above, at 5:00 a m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

Pericholecystitis

(duration) mos. ds.

CONTRIBUTORY (Secondary) Labors Pneumonia

Syph (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of Feb. 28, 1927

Was there an autopsy? [redacted]

What test confirmed diagnosis? Laboratory Diagnosis

(Signed) H. Blundell, M. D.

, 19 (Address) Balty City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

Date of Burial 19

20 UNDERTAKER: C. HAMPSON Jr. & M.

ADDRESS: Commissioner Health

MAR 31 1927

MAR 31 1927

1216

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

20744

## CERTIFICATE OF DEATH.

161 E 20744

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 803 N. Durham ST. 7-13 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Scruggs

(a) RESIDENCE NO. 803 N. Durham ST. WARD
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | C | S |

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3-30-27

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or 10 min. |
|---|---|---|---|---|
| | | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ...

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Louis Cole

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Kentucky

12 MAIDEN NAME OF MOTHER Maria Scruggs

13 BIRTHPLACE OF MOTHER (city or town) Kentucky
(State or country)

14 Informant
(Address)

15 Filed ..., 19 ...
1217 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-30 1927

17 I HEREBY CERTIFY, That I attended deceased from 3-30, 1927, to 3-30, 1927, that I last saw h— alive on 3-30, 1927, and that death occurred, on the date stated above, at 9:10 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. L. Berry, M. D.

, 19 (Address) 1510 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: 19

20 UNDERTAKER

ADDRESS

C. HAMPSON JONES, M. D. Commissioner of Health.

Spec.—1-10-21—M&T—1500 Bks.

E 20745

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20745

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Franklin Sq. Hospt. 124

CITY OF BALTIMORE: (No.) Fayette & Calhoun ST., 9-46 (WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ~~A Brown~~ A. Trade M. Jones

(a) RESIDENCE No. 1762 Homestead ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Lillian Jones

6 DATE OF BIRTH (month, day, and year) Dec. 19-1877

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 49 | 3 | 11 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman (Capt)

(b) General nature of industry, business, or establishment in which employed (or employer) 032

(c) Name of employer City Fire Dept.

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Edward Jones

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Ida Hardesty

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Mrs. Lillian Jones
(Address) 1762 Homestead St

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar
Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 30 1927

17 I HEREBY CERTIFY, That I attended deceased from 3-17- 1927 to 3-30- 1927 that I last saw him alive on 3-30- 1927 and that death occurred, on the date stated above, at 10:05 a.m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of the Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3-19-27

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) W Wallace Walker M. D.

, 19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Mem DATE OF BURIAL Apr 2 1927

20 UNDERTAKER Wm. J. Tickner & Sons ADDRESS N. Y. Pa

Spec.—12-9-25—A Co.—200 Blks.

2E 355

# HEALTH DEPARTMENT—CITY OF BALTIMORE

2E 20746

## CERTIFICATE OF DEATH.

× 44 E 20746

1-PLACE OF DEATH

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. JOHNS HOPKINS HOSPI St., 19 Ward)

2-FULL NAME William Layne

(a) RESIDENCE NO. Monastah W-Va St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred ___ yrs. mos 9 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widower |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 68 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Miner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Penn

(State or country)

PARENTS

10 NAME OF FATHER John Layne

11 BIRTHPLACE OF FATHER (city or town) Penn

(State or country)

12 MAIDEN NAME OF MOTHER Catherine Schultz

13 BIRTHPLACE OF MOTHER (city or town) West Va

(State or country)

14 Informant Records—

(Address) JOHNS HOPKINS HOSPI

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 31 1927

17

I HEREBY CERTIFY, That I attended deceased from Mar 22, 1927, to Mar 31, 1927, that I last saw him alive on Mar 31, 1927, and that death occurred, on the date stated above, at 4 P.M. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insuff

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Milton Sherbey, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Fairmount W Va | 3/31/27 |
| 20 UNDERTAKER | ADDRESS |
| Joseph Ahrens | 221 Bway |

APR 1 1927

Spec. 6-9-19 H. P. Co. 1000 Blks.

E 20747

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20747

## CERTIFICATE OF DEATH.

X 129

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: No. 2750 Wendover · St. 1608 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William W. Whittington

(a) RESIDENCE. No. 2750 Wendover · St., 46 WARD Friendship Md.
(Usual place of abode) (If nonresident give city)

Length of residence in city or town where death occurred — yrs. — 1 mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary J. Whittington

6 DATE OF BIRTH (month, day, and year) May 10 1852

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 74 | 10 | 21 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co Md

PARENTS

10 NAME OF FATHER Wm. Whittington

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co Md

12 MAIDEN NAME OF MOTHER Sarah E. Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co

14 Informant William W Whittington Jr
(Address) 2750 Wendover

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar
Per ARK

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31, 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 27, 1927, to March 31, 1927, that I last saw h[illegible] alive on March 30, 1927, and that death occurred, on the date stated above, at 9 15 a m.

The CAUSE OF DEATH* was as follows:

Nephritis Chronic

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Uremia

(duration) — yrs. — mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) [illegible], M. D.

3/31, 1927 (Address) 5[illegible] Gorsuch

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Friendship, Md | April 2 1927 |

20 UNDERTAKER Robt. J. Trood ADDRESS Friendship Md.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20748

## CERTIFICATE OF DEATH.

E 20748

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 3910 Fernhill Ave St. 15-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Johnson Gibson

(a) RESIDENCE NO. 3910 Fernhill Ave St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 Color or Race: W.

5 ~~Single~~, Married, ~~Widowed, or Divorced, (write the word)~~: Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Kathryn Gibson

6 DATE OF BIRTH (month, day, and year): Nov 11 1856

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 70 | 4 | 19 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Wood Worker

(c) Name of employer

9 BIRTHPLACE (city or town) Dundee, Scotland

(State or country)

PARENTS

10 NAME OF FATHER: James Gibson

11 BIRTHPLACE OF FATHER (city or town) _____ (State or country): Scotland

12 MAIDEN NAME OF MOTHER: Isabella Craig

13 BIRTHPLACE OF MOTHER (city or town) _____ (State or country): Scotland

14 Informant (Address): Mrs Kathryn Gibson 3910 Fernhill Ave

15 Filed 1927 C. HAMPSON JONES, M. D., Registrar

Per _____

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) arteriosclerosis

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy, M. D.

(Coroner)

March 31, 1927 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemt Date of Burial Apl 1 1927

20 ~~UNDERTAKER~~: Bertram W Fox ADDRESS 1923 W Lafayette Ave

Spec.—7-17-26—A Co.—200 Bks.

E 20749

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20749

## CERTIFICATE OF DEATH

X 36-094

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. Colonial Hospital St. 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Solomon H. Connolly

(a) RESIDENCE NO. Trilby Lane Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie M. Callahan

6 DATE OF BIRTH (month, day, and year) July 1st 1888

| 7 AGE | Years | Months | Days | IF LESS than 1 day ___ hrs. or ___ min.. |
|---|---|---|---|---|
| | 39 | 8 | 30 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Trilby Lane Co Md

PARENTS

10 NAME OF FATHER Charles Connolly

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ans Co Md

12 MAIDEN NAME OF MOTHER — Galt

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ans Co Md

14 Informant Mrs. F. Callahan

(Address) Centreville Md

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per APR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/31 1927

17 I HEREBY CERTIFY, That I attended deceased from 3/7, 1927, to 3/31, 1927, that I last saw him alive on 3/31, 1927, and that death occurred, on the date stated above, at 10:35 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Abs. of kidney, prostate and bladder

(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted ?

If not at place of death? ?

Did an operation precede death? Yes Date of 3/21/27

Was there an autopsy? No

What test confirmed diagnosis? Obtained by Xray

(Signed) Joseph V. Bonsall, M. D.

, 19 (Address) Colonial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Luke's Church Queen Anne's Co Md — Date of Burial April 1927

20 UNDERTAKER Gleason Remmel — ADDRESS 703 W. Lafayette Ave

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 20750

# CERTIFICATE OF DEATH.

E 20750

1-PLACE OF DEATH

City of BALTIMORE: (No. 1617 N. Broadway St., 8-17 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William W. Lowson

(a) RESIDENCE NO 1617 N. Broadway St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 9 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Widower |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie E. Proctor Lowson

6 DATE OF BIRTH (month, day, and year) June 7 1852

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 74 | 9 | 23 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mechanical Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) 320

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER John Lowson

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Walker

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Md

14 Informant Mary B. Lowson

(Address) 1617 N. Broadway

15 Filed 1927 C. HAMPSON JONES, M. D.

Per Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30 1927

17

I HEREBY CERTIFY, That I attended deceased from March 8, 1927, to March 30, 1927, that I last saw him alive on March 30, 1927, and that death occurred, on the date stated above, at 3.30 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ....yrs. ....mos. 20 ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr. Deegen, M. D.

, 19 (Address) 1702 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Loudon Park Cemetery April 1 1927

20 UNDERTAKER — ADDRESS

Chas. G. Black 742 W. North Ave

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20751

## CERTIFICATE OF DEATH.

E 20751

REGISTERED NO. 129

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [illegible] St. 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Barrett

(a) RESIDENCE NO. 320 Campbell St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Negro | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1864

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 58 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ?

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER James Barrett

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Emma ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant

(Address)

15 Filed APR 1 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29 1927

17 I HEREBY CERTIFY, That I attended deceased from March 28, 1927, to March 29, 1927, that I last saw him alive on March 27, 1927, and that death occurred, on the date stated above, at 6 5 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Chronic Myocarditis ?

(duration) yrs. ? mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Laboratory

(Signed) R Hoagen Smith, M. D.

Mch 29 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem Date of Burial March 31 1927

20 UNDERTAKER Laird Easton ADDRESS 6a av 926

Cor.—12-9-25—A Co.—200 Bks.

Gnatowski

E 20752

# HEALTH DEPARTMENT—CITY OF BALTIMORE

182 ✓

## CERTIFICATE OF DEATH.

E 20752

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE (No. Harbor Foot of Bradd St. 21-24 Ward)

2-FULL NAME Antoni Gnatowski

(a) RESIDENCE NO. 4205 West St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widower |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1878

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 48 | 9 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer City Water Department

9 BIRTHPLACE (city or town)

(State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Mrs. Mochnacki

(Address) 480 S Washington St

15 Filed R 1 1927 C. HAMPSON JONES, M. D. Registrar

Per

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acc. Drowning

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

(Signed) M. D.

(Coroner)

(Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Date of Burial 5/2/27 19

20 UNDERTAKER A W Ozagewski ADDRESS 2930 Eastern

Spec.—12-9-25—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20753

## CERTIFICATE OF DEATH.

162

E 20753

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1317 Herkimer St. 21-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Smith

(a) RESIDENCE NO. 1317 Herkimer St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar 30 1927

7 AGE: Years | Months | Days | IF LESS than 1 day hrs. or min. 14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country)

PARENTS

10 NAME OF FATHER Benjamin Smith

11 BIRTHPLACE OF FATHER (city or town)

(State or country) U/a

12 MAIDEN NAME OF MOTHER Helen Ebert

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country)

14 Informant Benjamin Smith

(Address) 317 Herkimer St

Filed R-1 1927 Per

HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/31/27 19

17 I HEREBY CERTIFY, That I attended deceased from 3/30/27, to 3/31/27, 19 27, that I last saw h— alive on 3/31/27, 19, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Cong. Atelectasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Bernard Fenig, M. D.

3/31/ 1927 (Address) 9 N Arlington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westen Date of Burial Apl 1 1927

20 UNDERTAKER John Fiddis ADDRESS 1200 N Fremont

Spec.-7-17-26—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20754

## CERTIFICATE OF DEATH

90 E 20754

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1424 Mt. Royal Ave. St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Lantz Sr.

(a) RESIDENCE NO. 1424 Mt. Royal Ave, St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary F. Lantz

6 DATE OF BIRTH (month, day, and year) January 28th. 1856

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min.. |
|---|---|---|---|---|
| | 71 | 2 | 1 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocery Business

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) New Windsor

(State or country) Maryland.

PARENTS

10 NAME OF FATHER James Lantz

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Richardson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland.

14 Informant Mary F. Lantz.

(Address) 1424 Mt. Royal Ave.

Filed APR - 1 1927 Registered

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29th. 1927.

17 I HEREBY CERTIFY, That I attended deceased from Jan 20. 1927. to March 29. 1927

that I last saw h. alive on March 29. 1927

and that death occurred, on the date stated above, at 10-30 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Decompensation (duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. R. Goldsborough, M. D.

, 19 (Address) 2923 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Loudon Park Cemetery. | 4/2/27 19 |

20 UNDERTAKER Chas. H. Braun & Son ADDRESS 1180 W. Mt. Royal Ave

Spec.—1-10-21—M&T—1500 Bks.

# E 20755 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

10-1001 E 20755

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1008 Forrest ST., 10-14 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Vaughan

(a) RESIDENCE NO. 1008 Forrest ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widowed |

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Patrick Vaughan

6 DATE OF BIRTH (month, day, and year) Feb 1 1874

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 53 | 1 | 24 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Thos. McAuliffe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Cath. Donohue

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Ruby Vaughan
(Address) 1008 Forrest St

C. HAMPSON JONES, M. D.

Filed APR 1 1927 R.J.C. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 30 1927

17

I HEREBY CERTIFY, That I attended deceased from Mar 27, 1927, to Mar 30, 1927.

that I last saw her alive on March 29, 1927

and that death occurred, on the date stated above, at 2 40 m.

The CAUSE OF DEATH* was as follows:

Central Lobar Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M. Fenlon, M. D.

Mar 31, 1927 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Cathedral | Apr 2 1927 |

UNDERTAKER Rita Wiedefeld ADDRESS 914 E Fremont Ave

Spec. -7-17-26 —A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20756

## CERTIFICATE OF DEATH

100-001

E 20756

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. University Hosp. St., 4-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine L Dunfee

(a) RESIDENCE NO. Laurel Md. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 da. How long in U. S. if of foreign birth? yrs. mos. da.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: Wh.

5 Single, Married, Widowed, or Divorced, (write the word): W.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): June 10th 1882

7 AGE: Years 44 Months 9 Days 21

IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Maid

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town): ?

(State or country) Virginia

PARENTS

10 NAME OF FATHER Frederic P. Dunfee

11 BIRTHPLACE OF FATHER (City or town)

(State or country) S. A.

12 MAIDEN NAME OF MOTHER Teressa Gill

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Frederic Dunfee

(Address) Laurel Md

15 Filed 1 1927

C. HAMPSON JONES, M. D. Registrar

Per R K

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/31/27 19

17 I HEREBY CERTIFY, That I attended deceased from Mar 25, 19 27 to Mar 31, 19 27

that I last saw h ed alive on Mar 31, 19 27.

and that death occurred, on the date stated above, at 1 30 a.m.

The CAUSE OF DEATH* was as follows:

Intramle Fracture Endocarditis

Septicemia

Acute infection Torpe delum.

(duration) yrs. 1 mos. da.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 da.

18 Where was disease contracted

if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E K Muller, M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ivy Hill Cemetery Laurel

Date of Burial: April 2nd 1927

20 UNDERTAKER: Elwood M Fenton

ADDRESS: Laurel Md

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

20757

## CERTIFICATE OF DEATH.

90

E 20757

1-PLACE OF DEATH

City of BALTIMORE: (No. 7 Belmar ave. St. 27-42 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Heffner

(a) RESIDENCE NO. 7 Belmar ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 82 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced ~~HUSBAND~~ (or) WIFE of Geo. K. Heffner

6 DATE OF BIRTH (month, day, and year) Jan. 20-1845

7 AGE

| Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|
| 82 | 2 | 11 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md.

PARENTS

10 NAME OF FATHER Benj. Heape

11 BIRTHPLACE OF FATHER (city or town)

(State or country) England

12 MAIDEN NAME OF MOTHER Elizabeth Kinkle

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs. Florence K. Heffner

(Address) 7 Belmar ave.

C. HAMPSON JONES, M. D.

15 Filed APR 1 1927 Per Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

March 31. 1927.

17

I HEREBY CERTIFY, That I attended deceased from Mar. 9 1927, to Mar. 31, 1927, that I last saw h[illegible] alive on Mar. 30, 1927, and that death occurred, on the date stated above, at 9 2. a. m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) ..... yrs. ..... mos. 22 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) 5 yrs. ..... mos. ..... ds.

18 Where was disease contracted at home

If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Symp.

(Signed) Florence C. Clarke, M. D.

March 31 1927 (Address) 2a Tuscan Apt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount Cem. Date of Burial: Apr. 2 1927

20 UNDERTAKER: Wm. E. Blacke ADDRESS: 927 N. Broadway

Spec.—1-10-21—M&T—1500 Bks.

E 20758

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 20758

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3508 Powhatan Ave ST. 15-61 WARD)

2-FULL NAME James Ross Gould Sr.

(a) RESIDENCE NO. 3508 Powhatan Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. 7 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White. | married. |

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Katherine J. Gould

6 DATE OF BIRTH (month, day, and year) Aug 17 1854

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 72 | 7 | 14 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cashier

(b) General nature of industry, business, or establishment in which employed (or employer) Freight Office

(c) Name of employer B. & O. R.R.

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER John R. Gould.

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Adele Huet Delahaye

13 BIRTHPLACE OF MOTHER (city or town) France
(State or country)

14 Informant Mrs. Robt Gould
(Address) Towson Md

15 Filed Apr 1 1927 HAMPSON JONES, M. D.
Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31, 1927

17 I HEREBY CERTIFY, That I attended deceased from March 30 1927 to March 31 1927

that I last saw him alive on March 31 1927

and that death occurred, on the date stated above, at 11 20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis.

Indefinite (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Indefinite.
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) Harry K. Assmus M. D.

Mar 31 1927 (Address) 3908 Hillsdale Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Greenmount Cem. | Apr. 4 1927 |
| 20 UNDERTAKER Wm Pickuer Sons | ADDRESS Towson Md |

Cor.—1-12-23—M&T—100 Bks.

Dorman's

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20759

100-001

E 20759

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 238 S. Dallas ST. 3-4 WARD)

2-FULL NAME Carrie M. E. Dorman.

(a) RESIDENCE NO. 238 S. Dallas ST., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced (write the word): married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sam Dorman

7 DATE OF BIRTH (month, day, and year): 1881

| AGE | Years | Months | Days | If LESS than 1 day, ....hrs. or ....min. |
|---|---|---|---|---|
| | 46 | | | |

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer: at home

BIRTHPLACE (city or town) (State or country): Balto Co. Md

10 NAME OF FATHER: David Bedford

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Sarah Bedford

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

Informant: Estella Jones
(Address): 46 N. Carey St.

Filed APR 1 1927

ESTELLA JONES, M. D.
Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar. 30 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

6 days (duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) ..... Duration ... yrs. mos. 1 ds.

(Signed) J. C. Clary, M. D.

Mar 31 1927 (Address) 1445 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death .... yrs., .... mos., .... ds. In the State .... yrs., .... mos., .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem.

DATE OF BURIAL: Apr. 2 1927

20 UNDERTAKER: Theodore White

ADDRESS: 113 S. Wolfe St.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

20760 — 31 E 20760

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. 7-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Foweth

(a) RESIDENCE NO. 719 Cedarcroft Rd. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary Foweth

6 DATE OF BIRTH (month, day, and year) July 2nd 1885

| 7 AGE | Years | Months | Days | IF LESS than 1 day ...hrs. or ...min.. |
|---|---|---|---|---|
| | 41 | 8 | 29 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret (Unknown)

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Mary C. Watson

(Address) 719 Cedarcroft Rd.

15 Filed APR - 1 1927 C. HAMPSON JONES, M. D. Registrar Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31, 1927

17 I HEREBY CERTIFY, That I attended deceased from March 27, 1927, to March 31, 1927

that I last saw him alive on March 31, 1927

and that death occurred, on the date stated above, at 6.50 A.m.

The CAUSE OF DEATH* was as follows:

Pneumonic phthisis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical diagnosis

(Signed) Isaac Benson, M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Hospital — Date of Burial Apr 1 1927

20 UNDERTAKER H. M. Cook — ADDRESS 502 E Monk Ave

Spec.—12-9-25—A Co.—200 Bks.

200967

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

49

E 20761

REGISTERED NO. E 20761

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. JOHNS HOPKINS HOSP St. 9-18 Ward)

2-FULL NAME Minnie Rudel

(a) RESIDENCE NO. 1708 Asquith St. Ally Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Rudel

6 DATE OF BIRTH (month, day, and year) Feb 11, 1866

| 7 AGE Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|
| 61 | 1 | 20 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany

(State or country)

PARENTS

10 NAME OF FATHER — Shumacher

11 BIRTHPLACE OF FATHER (city or town) Ger —

(State or country)

12 MAIDEN NAME OF MOTHER — Neuhaus

13 BIRTHPLACE OF MOTHER (city or town) Ger —

(State or country)

14 Informant Records —

(Address) JOHNS HOPKINS HOSP

15 Filed ....., 19 .....

Registrar

Per .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 31 1927

17

I HEREBY CERTIFY, That I attended deceased from Dec. 8, 1927, to Dec. 31, 1927, that I last saw h.. alive on Dec 31, 1927, and that death occurred, on the date stated above, at 3:40 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage.

Carcinoma of Lung

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

Pul Oedema. (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? Yes —

What test confirmed diagnosis? Autopsy

(Signed) Edwin Smith, M. D.

, 19 (Address) Johns Hopkins —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schwarz. Date of Burial Dec 2 1927

20 UNDERTAKER J. H. Cook ADDRESS 502 E Madison Ave.

Spec.–7-17-26—A Co.—200 Bks.

Dr Lemon 718 N Patterson Park Ave

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

49.V.

E 20762

E 20762 REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE; (No. 1409 Grunmount Ave St., 7 Ward) 27-48

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Graham

(a) RESIDENCE NO. 1409 Grunmount Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Katherine Graham

6 DATE OF BIRTH (month, day, and year): Nov 18. 1850

7 AGE — Years: 76 Months: 4 Days: 12

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Florist, Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Scotland

PARENTS

10 NAME OF FATHER: William Graham

11 BIRTHPLACE OF FATHER (City or town) (State or country): Scotland

12 MAIDEN NAME OF MOTHER: Margaret Dunbar

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Scotland

14 Informant: Katherine Graham

(Address) 1409 Grunmount Ave

15 Filed ..... 19 .....

APR 1 1927 HAMILTON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 30 19 27

17 I HEREBY CERTIFY, That I attended deceased from Dec 26, 1926, to Mar 30, 1927, that I last saw h— alive on " 29, 1927 and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Acute Exhaustion

Duration.

(duration) yrs. mos 30 ds.

CONTRIBUTORY (Secondary) Carcinoma Larynx

(duration) yrs. 5 mos ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Alan Brennan, M. D.

3/31. 1927 (Address) 18 W Pat Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Pk

Date of Burial: Apr 1 1927

20 UNDERTAKER: H. C. Cook

ADDRESS 500 E North Ave

Cor.—12-9-25—A Co.—200 Bks.

E 20763

# HEALTH DEPARTMENT—CITY OF BALTIMORE

11-001

## CERTIFICATE OF DEATH.

REGISTERED NO. E 20763

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital 4-10 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert A. Bishop

(a) RESIDENCE NO. 13-4 & Argyle Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Col | married |

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Katie Bishop

6 DATE OF BIRTH (month, day, and year) June 1853

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 73 | 9 | 28 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butler

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) N. York City

(State or country)

10 NAME OF FATHER Robt. A. Bishop

11 BIRTHPLACE OF FATHER (city or town) Jersey City

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Annapolis

(State or country)

14 Informant Mrs Katie Bishop

(Address) 13-4 Argyle Ave

APR - 1 1927

G. HAMPSON JONES, M. D.

Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Grippe

3 wks (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia bronchial

1 week (duration) yrs. mos. ds.

(Signed) M. T. Riley, M. D. (Coroner)

March 31, 1927 (Address) 1659 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Date of Burial Apr 2 1927

20 UNDERTAKER Franklin W Seitz ADDRESS 709 W 33 St

Spec.—1-10-21—M&T—1500 Bks.

E 20764

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 20764

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1730 W. Lanvale ST. 16-22 WARD)

2-FULL NAME Mrs. Lucy Jane Peters

(a) RESIDENCE NO. 1730 W. Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Dan Peters

6 DATE OF BIRTH (month, day, and year): Aug 1- 1886

7 AGE: Years 40 Months 8 Days 29 If LESS than 1 day, ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Richmond Co., Va

PARENTS

10 NAME OF FATHER: Peck ~~Peter~~ Veney

11 BIRTHPLACE OF FATHER (city or town) (State or country): Richmond Co. Va

12 MAIDEN NAME OF MOTHER: Sue Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Richmond Co. Va

14 Informant: Mrs Estelle Peck

(Address) 1500 Penna Ave

15 Filed Mar 31, 1927 J. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 29th 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 28th, 1927 to Mar. 29th 1927

that I last saw h[illegible] alive on Mar 29th 1927

and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(duration) few minutes yrs. mos ds.

CONTRIBUTORY (Secondary) Chr. Endocarditis

(duration) yrs. 8 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical Signs

(Signed) Jas Kelly Bell, M. D.

, 19 (Address) 713 Fremont

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: Apr 2 1927

20 UNDERTAKER: Lottie Gross

ADDRESS: 1405 N. Eden

Spec.—1-10-21 M&T 1500 Blks.

E 20765

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

89 E 20765

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1223 Mt Royal ave ST., 11-20 WARD)

2-FULL NAME Agnes. Gerry White

(a) RESIDENCE NO. 1223 Mt Royal av ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. 8 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed, or Divorced, (write the word)~~: Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mr. Edward Lucas White

6 DATE OF BIRTH (month, day, and year): July 27 1859

7 AGE — Years: 67 — Months: 8 — Days: 3 — If LESS than 1 day, ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Edenville Md

PARENTS

10 NAME OF FATHER: Dr Nathaniel R Gerry

11 BIRTHPLACE OF FATHER (city or town) (State or country): U. S. A.

12 MAIDEN NAME OF MOTHER: Margaret Darling

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Edgewood Md.

14 Informant: Mr Edward Lucas White

(Address) 1223 Mt Royal ave.

15 Filed MAR 1 1927 C. HAMPSON JONES, M.D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar. 30 1927

17 I HEREBY CERTIFY, That I attended deceased from October, 1924, to Mar. 30th, 1927, that I last saw her alive on " " 1927; and that death occurred, on the date stated above, at 12 p. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris. of less than 24 hours duration

yrs. mos. ds.

CONTRIBUTORY (Secondary): Arterio Sclerosis (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No. Date of X

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Clarence C. Price, M. D.

3-31-1927 (Address) 1705 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem

DATE OF BURIAL: 4-2 1927

20 UNDERTAKER: Henry W. Jenkins Sons Co

ADDRESS: Edward McCulloh

Spec —5-19-13—M. & T.—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20766
1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

46 E 20766
REGISTERED NO. C

CITY OF BALTIMORE: (No. 506 Gilmore ST. 19-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosa Williams

(Residence in Baltimore: No. 506 Gilmore St St. 30 yrs., mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) [illegible]

6-DATE OF BIRTH, Jan 16, 1852 (Month) (Day) (Year)

7-AGE, 75 yrs. 2 mos. 14 ds. If LESS than 1 day, ....hrs. or ....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work: Housework. (b) General nature of industry, business, or establishment in which employed (or employer): Of

9-BIRTHPLACE, (State or Country) Va

PARENTS.

10-NAME OF FATHER, Caleb Cuff

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rosa Richardson

(Address) 506 N Gilmore

15- Filed 1927, 191

THOMPSON JONES, M. D. Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 3-30-27, 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 2-15- 1927, to 3-30- 1927, that I saw h m alive on 3-29- 1927, and that death occurred, on the date stated above, at 12:15 m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma Uteri

(Duration) 6 mo yrs. mos. ds.

(Signed) [illegible] M. D.

3-31-1927 (Address) 1678 Baker

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem. DATE OF BURIAL, 4-1-27, 191...

20-UNDERTAKER, Edmund Hensley ADDRESS 578 Baker

Spec.—12-9-25—A Co.—200 Bks.

E 20767 HEALTH DEPARTMENT—CITY OF BALTIMORE 171 E 20767

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Balto City Hospls

City of BALTIMORE: (N.) Balto Md St. 4-37 Ward

2-FULL NAME Frederick Waire

(a) RESIDENCE NO. 406 S. 15th St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 Color or Race White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Catherine E. Waire

6 DATE OF BIRTH (month, day, and year) Nov 2 88

7 AGE: Years 38 Months 4 Days 29 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Riveter

(b) General nature of industry, business, or establishment in which employed (or employer) Labor

(c) Name of employer Bethelham Steel Co.

9 BIRTHPLACE (city or town) Maryland (State or country)

PARENTS

10 NAME OF FATHER Julius Waire

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Mary Betzger

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Balto City Hospl. (Address) Baltimore

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

R-1 1927 Per RH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-31 1927

17 I HEREBY CERTIFY, That I attended deceased from 3-23 1927 to 3-31 1927, that I last saw him alive on 3-31 1927, and that death occurred, on the date stated above, at 11.35 A m.

18 CAUSE OF DEATH was as follows: Cardiac failure, Alcoholic Delirium

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Alcoholic Psychosis Acute alcoholic Delirium

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted? Unknown

If not at place of death?

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) Wm. E. Lodmell M.D.

3/31/1927 (Address) Balto City Hospls

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Date of Burial 4/3 1927

20 UNDERTAKER Philip Herring ADDRESS 2017 Oliver St

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20768 ×188-001 E 20768

## CERTIFICATE OF DEATH.

E 20768

1-PLACE OF DEATH

REGISTERED NO. 11-244

City of BALTIMORE: (No. Md. Gen. Hospital St. 11-244 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank G. Williams

(a) RESIDENCE NO. 103 Kenwood Ave (Rosebury) St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma M. Williams

6 DATE OF BIRTH (month, day, and year) Jan. 12, 1870

| 7 AGE | Years | Months | Days | IF LESS than 1 day....hrs. or....min. |
|---|---|---|---|---|
| | 57 | 3 | 18 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bricklayer 51

(b) General nature of industry, business, or establishment in which employed (or employer) Beef Cohen & Sons Co.

(c) Name of employer

9 BIRTHPLACE (City or town)

(State or country) Balto. Co. Md.

PARENTS

10 NAME OF FATHER Gilson Williams

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto. Co. Md.

12 MAIDEN NAME OF MOTHER Eliz. Fitzgerald

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto. Co. Md.

14 Informant Emma M. Williams

(Address) 103 Kenwood Ave.

15 Filed APR 1 1927 C. HAMPSON JONES, M. D. Registrar

By M K

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Fracture of ribs and probably fracture of spine (accidental)

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (secondary) Caught between freight train & platform (duration) yrs. mos. ds.

(Signed) J. J. Hennessy, M. D. (Coroner)

April 1, 1927 (Address) 2502 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery Date of Burial apr. 2 1927

20 UNDERTAKER Zirkler & Zirkler ADDRESS 1739 E. Eager St.

Spec.—1-12-23—M&T—500 Blks.

E 20769 HEALTH DEPARTMENT—CITY OF BALTIMORE E 20769

# CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1112 Greenmount ST., 9-46 WARD)

REGISTERED NO. 100

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice J. Cleary

(a) RESIDENCE NO. 1112 Greenmount ave. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of —

7 DATE OF BIRTH (month, day, and year) Dec. 25-1849.

| 8 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 77 | 3 | 5-6 | |

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer): Housework

(c) Name of employer: Mrs. Baltimore, Md

10 BIRTHPLACE (city or town) (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER Edward M. Cleary

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER Elizabeth Bowling

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant Margaret E. Cleary (Address) 1112 Greenmount Ave City

15 Filed APR - 1 1927 HAMILTON JONES, M. D. Registrar Per RM

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 31. 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar. 15 1927 to Mar. 31, 1927.

that I last saw her alive on Mar. 30. 1927.

and that death occurred, on the date stated above, at 2.20 a. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

CONTRIBUTORY (Secondary) Cardiac Insufficiency (duration) yrs. mos. 5 ds.

(duration) yrs. 11 mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Benj. D. Hayden, M. D.

3/31/1927 (Address) 216 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Patrick's Cem. DATE OF BURIAL: Apr. 4 1927

20 UNDERTAKER: Zirkler & Zirkler ADDRESS: 1739 E Eager

Spec.—12-9-25—A Co.—200 Bks.

E 20770

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

113 E 20770

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSP. St. 35 Ward)

2-FULL NAME Ezra Slack

(a) RESIDENCE NO. 429 Cough St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 9-1926

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | | 5 | 23 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto Md.

PARENTS

10 NAME OF FATHER Harry Slack

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie Carmel

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Records

(Address)

15 Filed ..... 19 C. HAMPSON JONES, M. D. Registrar

1927 1924 JOHNS HOPKINS HOSP

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Jan 30, 19 27, to Mar 31, 19 27, that I last saw h alive on Mar 31, 1927, and that death occurred, on the date stated above, at 3.00 A m.

The CAUSE OF DEATH* was as follows:

Eczema

(duration) ....yrs. 5½ mos. ....ds.

CONTRIBUTORY (Secondary) Otitis media · bronchitis

(duration) ....yrs. ....mos. 2 wks ....ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) I. Ridgeway Trimble, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Old Heb Adelow Cem. Date of Burial 4-1- 1927

20 UNDERTAKER Jack Levins, 1431 E Balto ADDRESS

Spec.—12-9-25—A Co.—200 Pks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20771

## CERTIFICATE OF DEATH.

24

E 20771

REGISTERED NO.

1-PLACE OF DEATH South Balt Hosp

City of BALTIMORE: (No. 1713 S Hanover St. 9-47 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Allen Burkhardt

(a) RESIDENCE NO. 606 Chestnut Ave St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov. 8 1925

7 AGE: Years 1 Months 4 Days 23 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore,

(State or country) Md.

PARENTS

10 NAME OF FATHER Charles A Burkhardt

11 BIRTHPLACE OF FATHER (city or town) Baltimore,

(State or country) Md

12 MAIDEN NAME OF MOTHER Irene V Forck

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto Maryland

14 Informant Charles Burkhardt

(Address) 606 Chestnut Ave C.

15 Filed 1927 Per Registrar

C. HAMPSON JONES, M. D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from March 30 19 27, to April 1, 19 27,

that I last saw h.. alive on April 1, 19 27,

and that death occurred, on the date stated above, at 6 AM m.

The CAUSE OF DEATH* was as follows:

Epidemic Cerebro Spinal Meningitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. L. Miller, M. D.

, 19 (Address) South Balt. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Date of Burial: Apr 2, 1927

20 UNDERTAKER: Geo Clerk ADDRESS: 502 E Lombard

Cor.—12-9-25—A Co.—200 Bks.

20772

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

24-34 90 E 20772

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1688 Webster St. St. 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Ann Sullivan.

(a) RESIDENCE NO. 1688 Webster St. St. Ward Sykesville Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 5 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female. | White. | Widow. |

5a If ~~married~~ widowed, or ~~divorced~~ ~~husband of~~ (or) WIFE of Jeremiah Sullivan.

6 DATE OF BIRTH (month, day, and year) July 29 1847.

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 79 | 8 | 3 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland.

PARENTS

10 NAME OF FATHER Thomas Carroll.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Delaware.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Do not know.

14 Informant Edward J. Sullivan. (son)

(Address) 1688 Webster St.

15 Filed ..... 19 CHAMPSON JONES M. D. Registrar

1921

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) Otto C. Reinhardt M. D.
(Coroner)

4/1 · 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....5.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sykesville, Md. Date of Burial April 1927

20 UNDERTAKER Deer & Sons, Inc. ADDRESS Sykesville Md.

Spec.—12-9-25—A Co.—200 Blks.

(Sisp)

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20773 — E 20773

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospital 16-37 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Sisp

(a) RESIDENCE NO. Balto City Hospital Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| M | White | Single |

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1894

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 33 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Odd'ly

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Hospital Records

(Address)

Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per Ford

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 March. 29, 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 17, 1927, to March. 29, 1927

that I last saw him alive on March 29, 1927

and that death occurred, on the date stated above, at 2.35 p.m.

The CAUSE OF DEATH was as follows:

Pulm. Disease 9th & 10th

Dorsal Vertebra

Tuberculosis of both Kidneys

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Malaria

(duration) yrs. mos. 5 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of -

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) W. Blackwell, M. D.

, 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Mrs. Maud Tink | 3-31 |
| 20 UNDERTAKER | ADDRESS |
| Mr. Carmel | 4/2/27 |

Spec.—1-10-21—M&T—1500 Bks.

E 20774

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20774

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 100 Longwood St. (Ward) 27

REGISTERED No. 17

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Hunt

(a) RESIDENCE No. 100 Longwood St. WARD 27

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years 87 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER [illegible] Hunt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Martha Rae

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant [illegible] Hunt

(Address) 100 Longwood St.

15 APR 1 1927 Registrar

C. HAMPSON JONES, M. D.

Per [illegible]

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/30 1927

17 I HEREBY CERTIFY, That I attended deceased from 3/9, 1927, to 3/30, 1927, that I last saw h[illegible] alive on 3/30, 1927, and that death occurred, on the date stated above, at 7.30 P.M.

The CAUSE OF DEATH* was as follows: Uraemia infection

probably from Cystitis

(duration) 3 wks yrs. mos. ds.

CONTRIBUTORY – Hardening of Arteries (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Blood

(Signed) Percy T. Creed, M. D.

3/31, 1927 (Address) 1 Upland Road, Roland Pk.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery

DATE OF BURIAL Apr 2, 1927.

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor)

ADDRESS 108 W. NORTH AVE.

E 20775

# HEALTH DEPARTMENT--CITY OF BALTIMORE

## CERTIFICATE OF DEATH

5001 ✓
100 E 20775
REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No St Elizabeths Home - Chesmut Hill Ave ST. 9-47 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Velma Margaret Holcombe

(Residence in Baltimore: No. St Elizabeths' Home St.; yrs. mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: black

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word):

6 DATE OF BIRTH: March 4, 1926 (Month) (Day) (Year)

7 AGE: 1 yrs. mos. 26 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: ...
(b) General nature of industry, business, or establishment in which employed (or employer): ...

9 BIRTHPLACE (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Ralph Williams.

11 BIRTHPLACE OF FATHER (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Ella Holcombe

13 BIRTHPLACE OF MOTHER (State or country): Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) ...

(Address) ...

15 Filed C. HAMPSON JONES, 191 ... REGISTRAR

1927 Feb 1218

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: March 30, 1927 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 15, 1927 to March 30 1927 that I saw h-- alive on March 29, 1927 and that death occurred, on the date stated above, at 7 A. m. The CAUSE OF DEATH* was as follows:

Chronic Rhino-pharyngitis
(cause not ascertained)
(Duration) — unknown yrs. mos. ds

Contributory (SECONDARY) Bronchio Pneumonia
(Duration) yrs. mos. 2 ds.

(Signed) Francis J. Lyde M. D.
March 30, 1927. (Address) 2005 E. Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence ...

19 PLACE OF BURIAL OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL: ..., 191...

20 UNDERTAKER: Commissioner Health. — ADDRESS: APR 1 - 1927

For WM. S. THOMAS

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

161-501

E 20776

E 20776

## CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. Johns Hopkins Hospital. St. 13-52 Ward)

2-FULL NAME Baby Livesay

(a) RESIDENCE NO. 3305 Beech Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 Color or Race White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 29, 1927

| 7 AGE | Years | Months | Days | IF LESS than 1 day 4 hrs. or ..... min. |
|---|---|---|---|---|
| | | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ...0d

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) .....

(State or country) U. S.

PARENTS

10 NAME OF FATHER Edward Livesay

11 BIRTHPLACE OF FATHER (city or town) .....

(State or country) Md.

12 MAIDEN NAME OF MOTHER Viola Frey

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) Va.

14 Informant H. Hoerner Jr.

(Address) Johns Hopkins Hospital

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

1927 Reg. 1219

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 29 19 27

17

I HEREBY CERTIFY, That I attended deceased from 3-29, 19 27, to 3-29, 19 27

that I last saw her alive on 3-29, 19 27,

and that death occurred, on the date stated above, at 5-15 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity (7 mo baby)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted —

If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) H. Hoerner, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

JOHNS HOPKINS HOSPITAL

Commissioner Health.

APR 1 - 1927

Spec.-7-17-26—A Co.—200 Bks.

E 20777

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

90 E 20777

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1604 Milliman St., 7-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Jane Haddaway

(a) RESIDENCE NO. 1604 Milliman St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robt. L. Haddaway

6 DATE OF BIRTH (month, day, and year) May 4th 1842

| 7 AGE | Years | Months | Days |
|---|---|---|---|
| | 74 | 10 | 26 |

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Thomas J. Haddaway

(Address) 1333 N. Patterson Park Ave

15 Filed ..... 19 .....

Per ..... Registrar

C. HAMPSON JONES, M. D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31st 1927

17 I HEREBY CERTIFY, That I attended deceased from April, 1926, to March 31, 1927, that I last saw her alive on March 30, 1927, and that death occurred, on the date stated above, at 4:30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic vascular heart disease

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

(Address) 706 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Baltimore Cemetery Inc | April 2nd 1927 |
| **20 UNDERTAKER** | **ADDRESS** |
| Robt. J. Turner. | 1442 N. Broadway Baltimore Md. |

20778

# HEALTH DEPARTMENT—CITY OF BALTIMORE

66 E 20778

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1513 Bolton St St. 14-25 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John. B. Hedian

(Residence in Baltimore: No. 1513 Bolton St

St.; yrs. mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, OR ~~DIVORCED~~, (Write the word.): Married

6-DATE OF BIRTH: February 2nd (Month) (Day), 1888 (Year)

7-AGE: 39 yrs. 1 mos. 28 ds.

If LESS than 1 day, ....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Stock Broker
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER: Alfred M. Hedian

11-BIRTHPLACE OF FATHER (State or Country): Baltimore Md

12-MAIDEN NAME OF MOTHER: Ella Healy

13-BIRTHPLACE OF MOTHER (State or Country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. M. Hedian

(Address) 1513 Bolton St

15-

FILED 1927, 191.. C. HAMPSON JONES, M. D. Registrar.

Per ARH

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 30, (Month) (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute alcoholism

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D. (Coroner.)

April 1, 1927 (Address) 780 Edgewood Rd.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL: New Cathedral

DATE OF BURIAL, 4-2, 1927

20-UNDERTAKER: A. F. Jenkins & Son

ADDRESS: McCulloh

Spec.—7-17-26—A Co.—200 Bks.

E 20779

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 ✓

E 20779

## CERTIFICATE OF DEATH

1-PLACE OF DEATH Union Memorial Hospital REGISTERED NO. 12-49

City of BALTIMORE: (No. 33d & Calvert St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Emil Heims

(a) RESIDENCE NO. 3537 Newland St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 3 mos. — ds. How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 21, 1901

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..hrs. or ..min.. |
|---|---|---|---|---|
| | 26 | 2 | 10 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of indostry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Rhode Island

(State or country)

PARENTS

10 NAME OF FATHER Arthur Heims

11 BIRTHPLACE OF FATHER (City or town) Rhode Island

(State or country)

12 MAIDEN NAME OF MOTHER Henrietta Cromwell

13 BIRTHPLACE OF MOTHER (city or town) Rhode Island

(State or country)

14 Informant Hospital Record

(Address)

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1, 1927

17 I HEREBY CERTIFY, That I attended deceased from March 27, 1927, to April 1, 1927, that I last saw him alive on April 1, 1927, and that death occurred, on the date stated above, at 1:40 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Chronic nephritis

(duration) yrs. ? mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr. W. L. Hannah M. D.

. 19 (Address) Union Memorial Hospital 33d & Calvert Sts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Providence R. I. Date of Burial April 1st 1927

20 UNDERTAKER Henry J. Justice & Sons ADDRESS 1711 Eutaw Pl.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 20780

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20780

100-001

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 27 E. Southern Av. ST. 27-6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriet Eileen Bowling

(a) RESIDENCE. NO. 27 E. Southern Av. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Female | White | Baby |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Father Oliver T. Bowling

6 DATE OF BIRTH (month, day, and year) Oct. 6 '26

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | | 5 | 25 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Oliver T. Bowling

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Groves

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pennsylvania

14 Informant: Oliver T. Bowling
(Address) 27 E. Southern Ave.

15 Filed 1927 C. HAMPSON JONES, M. D., Registrar
Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1 1927

17 I HEREBY CERTIFY, That I attended deceased from March 16 1927 to April 1 1927 that I last saw h[illegible] alive on March 31 1927 and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary) Congenital Idiocy

(duration) Life yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum Lupin

(Signed) W. Bagram, M. D.

19 (Address) 24 Zy N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery — DATE OF BURIAL: April 3 1927

20 UNDERTAKER: Wilbur W. Sliver — ADDRESS: 1018 Edmondson Ave

Cor.—12-9-25—A Co.—200 Bks.

E 20781

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20781

## CERTIFICATE OF DEATH.

× 187-006

REGISTERED NO. _____

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James M. Marshall

(a) RESIDENCE NO. 14 Dover at St. Pt Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 11, 1911

7 AGE — Years: 16 Months: 8 Days: 17 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Wm Marshall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: M. Schifflett

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Mrs Mary Schifflett (Address) 30 Cameron Highlands

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per _____

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apl 1 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to h. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract. femur Rt
accidentally sustained by
being struck by auto at Balto Pt

Duration yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) W. H. Riley M. D.
(Coroner)

Apl 1, 1927 (Address) 1659 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In this State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Charlottesville Va Date of Burial: Apl 1 1927

20 UNDERTAKER: W. W. Cole ADDRESS: 502 Aisquith

Spec—12-9-25—A Co—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20782

CERTIFICATE OF DEATH.

E 20782

1-PLACE OF DEATH

City of BALTIMORE: (No. 3705 Elmore St. 13 52 Ward)

REGISTERED NO. 57

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth A. Caudelley

(a) RESIDENCE NO. 3705 Elmore St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 4yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Charles R Caudelley

6 DATE OF BIRTH (month, day, and year): Nov 6, 1859

7 AGE: Years 67 | Months 4 | Days 24 | If less than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country) Md

PARENTS

10 NAME OF FATHER: Philip Dare

11 BIRTHPLACE OF FATHER (city or town): Balto

(State or country) Md

12 MAIDEN NAME OF MOTHER: Margaret Caples

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Anne Arundel Co

14 Informant (Address): C. C. Caudelley 3705 Elmore

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3-30 1927

17 I HEREBY CERTIFY, That I attended deceased from 3-24, 1927, to 3-30, 1927, that I last saw her alive on 3-30, 1927, and that death occurred, on the date stated above, at 5.00 P m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) J. H. Wilson M. D.

, 19 (Address) 873 W 36th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem Date of Burial April 2 1927

20 UNDERTAKER: Chenoweth Son. ADDRESS 3616 Chestnut ave

Spec.—12-9-25—A Co.—200 Bks.

E 20783

# HEALTH DEPARTMENT—CITY OF BALTIMORE

118-027

E 20783

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home & Infirmary REGISTERED NO.

City of BALTIMORE: (No. Broadway & Jarvis St.) (Ward) 15th

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Ely Gill

(a) RESIDENCE NO. 2205 Allendale Road Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced WIFE of (or) HUSBAND of: Florence Hughes Gill

6 DATE OF BIRTH (month, day, and year): June 6 1864

7 AGE: Years 62 | Months 9 | Days 21 | IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Sales man

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Dr. Charles M. Gill

11 BIRTHPLACE OF FATHER (city or town): Baltimore

(State or country): Md

12 MAIDEN NAME OF MOTHER: Catherine M. Hemmeter

13 BIRTHPLACE OF MOTHER (city or town): Baltimore

(State or country): Maryland

14 Informant: Mrs. Florence Hughes Gill

(Address) 2205 Allendale Road

15 Filed 1927 C. HAMPSON JONES, Registrar

Per Reed

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

March 31st 1927.

17

I HEREBY CERTIFY, That I attended deceased from Mar. 30th, 19 27, to Mar 31st, 19 27, that I last saw h[illegible] alive on Mar 31st, 19 27, and that death occurred, on the date stated above, at 11:45 P.m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction & gangrene - loop of bowel

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Mar 31, 1927

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Henry C. P. Dixon M. D.

, M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional spaces.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Glen Mount Cem. Date of Burial: Apr. 4 1927

20 UNDERTAKER: Joseph B. Cook ADDRESS: 1003 N. Gilmor St.

Spec.–7-17-26—A Co.—200 Bks.

E 20784

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20784

## CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 835 S. Ellwood Ave St. 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doris M. Daggs

(a) RESIDENCE NO. 835 S. Ellwood Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. da. How long in U. S. if of foreign birth? yrs. mos. da.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 23. 1925

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min.. |
|---|---|---|---|---|
| | 1 | 7 | 8 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Charles W. Daggs

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Missouri

12 MAIDEN NAME OF MOTHER Elsie V. Woodward

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md.

14 Informant Charles W. Daggs

(Address) 835 S Ellwood Ave

15 1927 C. HAMPSON JONES, M. D. Registrar

Per R.R.S.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31 1927

17 I HEREBY CERTIFY, That I attended deceased from 3-25 1927 to 3-31 1927.

that I last saw h.er alive on 3-30 1927.

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos. 3 da.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 da.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typing

(Signed) J. Reid Dunning M. D.

3.31. 1927 (Address) 800 N. Patterson Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Oak Lawn Cemetery

Date of Burial April 2 1927

20 UNDERTAKER Henry Sonder & Sons Inc

ADDRESS 1710 Fleet St.

Spec.—7-17-26—A Co.—200 Bks.

E 20783

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

90 E 20785

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 615 S. Decker Ave St. 1-V Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Platt

(a) RESIDENCE NO. 615 S Decker Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Platt

6 DATE OF BIRTH (month, day, and year) June 24, 1840

| 7 AGE | Years | Months | Days | IF LESS than 1 day ____ hrs. or ____ min.. |
|---|---|---|---|---|
| | 86 | 9 | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER John Becher

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Not Known

14 Informant Mrs Mary Kreamer

(Address) 615 S Decker Ave

15 Filed ____, 19____ Registrar

1927 C. HAMPSON JONES, M. D.

Par

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30 1927

17 I HEREBY CERTIFY, That I attended deceased from March, 1926, to March 30, 1927.

that I last saw her alive on March 30, 1927.

and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Joseph Pokorny M. D.

19 (Address) 2200 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Holy Redeemer Cemetery | April 2 1927 |
| **20 UNDERTAKER** | **ADDRESS** |
| Henry Sander & Sons Inc | 1710 Fleet St. |

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20786

E 20786

## CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1236 Dillwood Ave St. 13-57 Ward)

2-FULL NAME Mary L Manke

(a) RESIDENCE NO. 1236 Dillwood Ave St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | W | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Manke

6 DATE OF BIRTH (month, day, and year) July 4 1877

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 49 | 8 | 27 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) Md.

PARENTS

10 NAME OF FATHER Joseph Solbach

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Md.

12 MAIDEN NAME OF MOTHER Louise Buchmyer

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Md

14 Informant Henry Manke

(Address) 1236 Dillwood Ave

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gas Poisoning

Suicide

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

(duration) .....yrs. .....mos. .....ds.

(Signed) J. Harrison M. D. (Coroner)

4/1, 19 27 (Address) 3692 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Date of Burial April 5 19 27

20 UNDERTAKER W. M. Cook ADDRESS 301 E Madison Ave

Cor.—12-9-25—A Co.—200 Bks.

E 20787

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-01 E 20787

## CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Bal City Hospital St. 1-3 Ward)

2-FULL NAME Joseph Haas

(a) RESIDENCE NO. 2214 Essex St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | white | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) 1877

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 50 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salt maker

(b) General nature of industry, business, or establishment in which employed (or employer) Salt 80

(c) Name of employer Self.

9 BIRTHPLACE (city or town) Balto City

(State or country)

PARENTS

10 NAME OF FATHER Frank Haas

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Balto City

12 MAIDEN NAME OF MOTHER Anna Steinbach

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Pennsylvania

14 Informant Wilhelmina Haas

(Address) 1258 Lakewood Ave

15 Filed Apr 3 1927 HAMILTON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 31 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Lobar Pneumonia

(duration) .....yrs. .....mos. 1 .....ds.

CONTRIBUTORY (Secondary) _____

(duration) .....yrs. .....mos. .....ds.

(Signed) James M Carton M. D.
(Coroner)

4 1, 1927 (Address) York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence 2214 Essex St

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Date of Burial Apr 2 1927

20 UNDERTAKER William Cook ADDRESS 507 E Hoffman

Formally lived in Rooming House, Where Unknown

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20788

38 E 20788

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Balto City Hospls 3-31-27

REGISTERED NO.

City of BALTIMORE: (No. Balto Md. St. Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Chris Nicholas

(a) RESIDENCE NO. Unknown St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? / yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1894

| 7 AGE 33 | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 32 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 6 6

(b) General nature of industry, business, or establishment in which employed (or employer) Mill work

(c) Name of employer Unknown

9 BIRTHPLACE (city or town)

(State or country) Greece

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Balto City Hospls

(Address) Balto Md

Filed 1927 19

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

3-31-27

17 I HEREBY CERTIFY, That I attended deceased from 2-28- 19 27 to 3-31- 19 27

that I last saw h.m alive on 3-31 19 27

and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Exhaustion, Toxic

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxic + Luetic Psychosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Clinical findings

What test confirmed diagnosis?

(Signed) John F. Carruth, M. D.

, 19 (Address) Fortune City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westlawn Cem Apr 4 19 27

Date of Burial

20 UNDERTAKER W. E. Cook

ADDRESS 502 E North Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

20789

## CERTIFICATE OF DEATH.

129 E 20789

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1104 N. Saratoga (St.) 18 (Ward)

2-FULL NAME John A. Doyle

(a) RESIDENCE. No. 1104 N. Saratoga St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 7 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 15-1864

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 62 | 7 | 15 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) State Dept.

(c) Name of employer Baltimore City

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Doyle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine McGivney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Miss Ellen Doyle (Address) 1104 N. Saratoga St.

15 1927 C. HAMPSON JONES, M. D. Registrar

Per RCA

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 30- 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 27. 1927. to Mar 29. 1927.

that I last saw him alive on Mar 29. 1927.

and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis
1
Arteriosclerosis —

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

4/1 (Signed) A Keller Hennessy M. D.

1927 (Address) 2000 Hollins St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL Apl. 2, 1927

20 UNDERTAKER Elmer F. Conklin, — ADDRESS 924 E. Eager St.

Spec.—1-12 23—M&T—500 Blks.

E 20790

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20790

## CERTIFICATE OF DEATH.

37

1-PLACE OF DEATH St Josephs Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Caroline & Oliver ST. 24-33 WARD)

2-FULL NAME Leo. Norton

(a) RESIDENCE NO. 907. Light ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male. | White | Single |

6 If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) Nov. 29 - 1893

| AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 33 | 4 | 0 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Musician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore, Md. (State or country)

10 NAME OF FATHER Edward - L. Norton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mary Hazen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

Informant Hosp. Records

(Address) St. Joseph's Hosp

Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29 19 27

17

I HEREBY CERTIFY, That I attended deceased from March 24, 19 27, to March 29, 19 27, that I last saw him alive on March 29, 19 27, and that death occurred, on the date stated above, at 5:17 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.
Bronchial Pneumonia

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Clement K. Thomas, M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem.

DATE OF BURIAL Apr. 2 19 27

20 UNDERTAKER Margaret S. Flynn

ADDRESS 1422 Light St.

Spec.—1-10-21—M&T—1500 Bks.

E 20791

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 20791

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Maryland General Hosp. (ST.) 914-24 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Owen Feeney

(a) RESIDENCE NO. 1724 Eld. St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs. Owen Feeney

6 DATE OF BIRTH (month, day, and year): 1-24-1867

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 60 | 2 | 2 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Watchman

(b) General nature of industry, business, or establishment in which employed (or employer): 060

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: William Feeney

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Bridget Kenolan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Hosp. Records

15 FILED 2 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-1- 1927

17 I HEREBY CERTIFY, That I attended deceased from 3-31-27, 19, to 4-1-, 1927, that I last saw h(M)alive on 4-1-, 1927, and that death occurred, on the date stated above, at A m.

The CAUSE OF DEATH* was as follows:

Empyema

(duration) 2 weeks (?) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4-1-27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. C. Zimmerman, M. D.

, 19 (Address) Fond Du Lac Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross A. G. C.

DATE OF BURIAL: 4/4 1927

20 UNDERTAKER: Margaret L. Flynn

ADDRESS: 1422 Eutaw St.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20792

38 E 20792

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [illegible] St. 27-31 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Howard

(a) RESIDENCE NO. 129 W. Hill St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Negro | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1869

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 58 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of indnstry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md

PARENTS

10 NAME OF FATHER Henry Howard

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Francis —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant

(Address) Records

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31 1927

17

I HEREBY CERTIFY, That I attended deceased from January 15, 1927, to March 31, 1927, that I last saw him alive on March 31, 1927, and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Internal Sclerosis

Aneurysm aorta arch

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Aneurysmal rupture into trachea

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? General & Laboratory

(Signed) R. Hooper Lumb, M. D.

April 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem Date of Burial 4/1 1927

20 UNDERTAKER Samuel B. Hensley ADDRESS 1124 N Eden

Cor.—12-9-25—A Co.—200 Bks.

E 20793

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20793

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baugh Council Co. St. 11-25 Ward)

City of BALTIMORE (No.

2-FULL NAME John H. Joyner

(a) RESIDENCE NO. 425 N. Monument St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year) Feb, 1874

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 53 | 1 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va

(State or country)

PARENTS

10 NAME OF FATHER John Joyner

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Susan Joyner

(Address) 425 Linden Monument St

15 Filed ....., 19.. A. M. ..... Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Accident

Multiple fractures Lacerations Contusions (Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Shock Inst.

Duration ..... yrs. ..... mos. ..... ds.

Signed Harry C Slade M. D.

(County) (Address) 1430 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ..... mos., ..... ds. In the State ..... yrs., ..... mos., ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem Date of Burial 4/2 1927

20 UNDERTAKER Samuel T Hensley ADDRESS 1128 E Balto

CHAMPSON JONES M.D.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

20794 — CERTIFICATE OF DEATH. — E 20794

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1607 Presbury St. 15-21 Ward) REGISTERED NO. C 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eva Talbott

(Residence in Baltimore: No. 1607 Presbury St.; 4 yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, November 21, 1893 (Month) (Day) (Year)

7-AGE, 33 yrs. 4 mos. 11 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laundress
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, William Makel

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Mary Barbary Makel

13-BIRTHPLACE OF MOTHER (State or Country), Washington D. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Barbara Hawkins

(Address) 1607 Presbury St.

15-

Filed ..... 1927 C. HAMPSON JONES, M. D. Registrar.

Per .....

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 31 1927 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 12 1927, to March 31 1927, that I saw her alive on March 30 1927, and that death occurred, on the date stated above, at 4-30 p.m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(Duration) ..... yrs. ..... mos. 19 ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm. E. Daugherty M. D.

April 1, 1927 (Address) 1602 Bruce St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, April 3, 1927

UNDERTAKER J. Jones — ADDRESS W. Lafayette

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20795 E 20795

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1604 Vincent ST. 15-21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maynard McKenney

(a) RESIDENCE NO. 1604 Vincent ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Laura McKinney

6 DATE OF BIRTH (month, day, and year): Unknown 1883

7 AGE: Years 42; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): "

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): "

14 Informant (Address): Laura McKinney 1604 Vincent

15 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 31 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 27, 1927, to May 31, 1927.

that I last saw h[illegible] alive on May 31, 1927.

and that death occurred, on the date stated above, at 1:40 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Gastro Enteritis

(duration) yrs. mos. 30 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) B. N. Hatcher, M. D.

6/1, 1927 (Address) 1115 Penna Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem

DATE OF BURIAL: June 3 1927

20 UNDERTAKER: Jno. F. Blacklston

ADDRESS: 1702 Madison

Spec.—1-12-23—M&T—500 Bks.

20796

# HEALTH DEPARTMENT—CITY OF BALTIMORE

20796

## CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1424 Bolton (ST.) 14-20 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriett Weir Davis

(a) RESIDENCE NO. 1424 Bolton ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

6a If married, ~~widowed~~, or ~~divorced~~ ~~HUSBAND~~ (or) WIFE of: Charles B Davis

6b DATE OF BIRTH (month, day, and year): Sept 17 1881

7 AGE: Years 45 47 | Months 6 7 | Days 14 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): N. J.

PARENTS

10 NAME OF FATHER: Joseph R Weir

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. J.

12 MAIDEN NAME OF MOTHER: Emma Garvey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. J.

14 Informant: Mrs Joseph Weir

(Address) Asbury Park N J

15 Filed 2 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 1st 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 20 1927 to Apr 1st 1927 that I last saw her alive on Apr 1st 1927 and that death occurred, on the date stated above, at on

The CAUSE OF DEATH* was as follows:

Myocarditis - Edema of Lungs.

(duration) — yrs. — mos. 15 ds.

CONTRIBUTORY (Secondary): Asthma

(duration) 7 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) S A Dodds, M. D.

Apr 2 1927 (Address) 904 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Park N. J.

DATE OF BURIAL: April 2 27

20 UNDERTAKER: Henry H Jenkins & Son

ADDRESS: Eleventh Ave. Belmar N.J.

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20797 E 20797

## CERTIFICATE OF DEATH. × 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 691 Pierce ST. 176 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha B. Bartlett

(a) RESIDENCE NO. 691 Pierce ST., WARD

(Usual place of abode) (If non-resident give city or town and State) Belleross. N.C

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Colored | Married |

5a If married, widowed, or divorced ~~HUSBAND of~~ WIFE of Mayor Bartlett

6 DATE OF BIRTH (month, day, and year) Oct 23. 1904

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 22 | 5 | 8 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Belleross N.C.

PARENTS

10 NAME OF FATHER Earnest Barnard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Belleross N C

12 MAIDEN NAME OF MOTHER Katie Dozier

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Belleross N C

14 Informant (Address) Katie Barnard 691 Pierce St

15 Filed 2 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/31/ 1927

17 I HEREBY CERTIFY, That I attended deceased from 3/21 , 1927 , to March 31 , 1927 , that I last saw her alive on 3/30/1 , 1927 , and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows: Pneumonia Lobar

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) –

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? N. Carolina

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Ellis, M. D.

4/1 , 1927 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Belleross N. C.

DATE OF BURIAL 4/2 1927

20 UNDERTAKER Byron Wright

ADDRESS 1218 McElderry

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20798

## CERTIFICATE OF DEATH.

13 E 20798

1-PLACE OF DEATH

City of BALTIMORE: (No. 1423 W. Lanvale St. 16-22 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME ~~Mrs~~ Mary E. Smith

(a) RESIDENCE NO. 1423 W. Lanvale St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | colored. | Single - |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 12. 1925

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 1 | 3 | 19 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town)

(State or country) Balto Md.

PARENTS

10 NAME OF FATHER Wallace F. Smith.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) — Va —

12 MAIDEN NAME OF MOTHER Gusten Rich.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) — — Va.

14 Informant Wallace F. Smith.

(Address) 1433. W. Lanvale St.

15 April 2 1927 C. HAMPSON JONES, M. D.

Per — Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) March 31, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute gastro-enteritis
Indigestion of dietary
Malaria (duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) J. T. Hennessy M. D.
(Coroner)

April 1, 1927 (Address) 718 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs.. ....mos.. ....ds. In the State ....yrs.. ....mos.. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — Date of Burial: April 2 1927

20 UNDERTAKER: Mrs Geo. H. Dennis for T. B. Nelson — ADDRESS: 1303 Pressman St

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20799

## CERTIFICATE OF DEATH

100-001

E 20799

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Univ. Hospital St. 18-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Shanahan

(a) RESIDENCE NO. 41 Arlington Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: m

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 7 1853

7 AGE 54 Years Months 4 Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED Retd Worker

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Carrigan & Toy Co

9 BIRTHPLACE (city or town)

(State or country) Ireland

PARENTS

10 NAME OF FATHER William Shanahan

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER M Cunningham

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Frank Wilson

(Address) 1130 W. Lombard

15 Filed Apr 7, 1927 C. HAMPSON JONES, M. D.

Per Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/31 1927

17 I HEREBY CERTIFY, That I attended deceased from 3/27, 1927, to 3/31, 1927, that I last saw him alive on 3/31/27, 19, and that death occurred, on the date stated above, at 10:30 P m.

The CAUSE OF DEATH* was as follows:

1st Terminal Pneumonia

2nd Serous Meningitis

(duration) yrs. 2 mos ds.

Contributory (Secondary) Chronic alcoholism

(duration) Several yrs. mos ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) E K Mueller, M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — Date of Burial: April 4 1927

20 UNDERTAKER: John J Fields — ADDRESS: 1200 W Lombard

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

20800

CERTIFICATE [redacted] E 20800

161-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 845 N. Eutaw. ST. 11-24 WARD)

2-FULL NAME Infant of Wilmer B. & Helen C. Koller

(a) RESIDENCE NO. 845 N. Eutaw ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) April 1 1927

| AGE | Years | Months | Days | If LESS than 1 day, hrs or 30 min |
|---|---|---|---|---|
| | 0 | 0 | 0 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Wilmer B. Koller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Helen C. Herman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant (Address): Mrs. Helen C. Koller 845 N. Eutaw St

15 Filed APR 2 1927, 19 C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1 1927

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1927, to April 1, 1927.

that I last saw h[illegible] alive on April 1, 1927

and that death occurred, on the date stated above, at 8.30 P m

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Premature Birth,

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. M. Hampson, M. D.

APR 2 1927 (Address) 826 N. Carrollton Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem. DATE OF BURIAL: Apr 2 1927

20 UNDERTAKER: Wm. J. Pickett & Sons ADDRESS: Northern

Cor.—12-9-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20801

CERTIFICATE OF DEATH. + 197

E 20801

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital, 45-72 St., Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Arthur J. Connolley

(a) RESIDENCE NO. Balto. Co. Lansdowne St., Md. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Viola Connolley

6 DATE OF BIRTH (month, day, and year): Jan 5 1888

7 AGE: Years 39 Months 2 Days 26 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Maintainace Man 1086

(b) General nature of industry, business, or establishment in which employed (or employer): at Gas & Elect Co

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country)

PARENTS

10 NAME OF FATHER: M. R. Connolley

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Balto

12 MAIDEN NAME OF MOTHER: C. McKewen

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Balto

14 Informant: Viola Connolley

(Address): Lansdowne Md

15 Filed. 2 1927 16 G. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 31st 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal Hemorrhage 9 1/2 hrs

CONTRIBUTORY (Secondary) Shot in stomach

(duration) yrs. mos. ds.

(Signed) Thos. B. Hottois M. D.

(Coroner)

Apr 1st 1927 (Address) Curtis Bay, Balto. Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — Date of Burial: April 1927

20 UNDERTAKER: John Fields — ADDRESS: 1200 W Lombard

Spec.—1-10-21—M&T—1500 Bks.

Harris

20802

# HEALTH DEPARTMENT—CITY OF BALTIMORE

92 E 20802

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2753 N. Wolfe ST. 15-68 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Harris

(a) RESIDENCE NO. 2753 N. Wolfe ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? 62 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | white | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hyman Harris

6 DATE OF BIRTH (month, day, and year) Aug 5 1865

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or min. |
|---|---|---|---|---|
| 61 62 | 7 | 3 4 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Warsaw

PARENTS

10 NAME OF FATHER Harry Bustanes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Warsaw

12 MAIDEN NAME OF MOTHER Sarah

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Warsaw

14 Informant Hyman Harris

(Address) 2753 N. Wolfe ave

15 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1 1927

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1927, to April 1, 19..., that I last saw h alive on April 1, 1927, and that death occurred, on the date stated above, at 7 30 a.m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H C Hagen, M. D.

April 1. 1927 (Address) 1,02 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship DATE OF BURIAL 4/3 1927

20 UNDERTAKER Jack Lewis 1489 E Balto st ADDRESS

Cor.—12-9-25—A Co.—200 Bks.

E 20805 HEALTH DEPARTMENT—CITY OF BALTIMORE E 20803

CERTIFICATE OF DEATH.

186-003

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hospital 11-24 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robt. Lee Morton

(a) RESIDENCE NO. 1103 Mc Culloh St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | colored | single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 17, 1925

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 1 | 9 | 14 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) N. C.

PARENTS

10 NAME OF FATHER James Morton

11 BIRTHPLACE OF FATHER (city or town)

(State or country) N. C.

12 MAIDEN NAME OF MOTHER Arie Wilson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) N. C.

14 Informant James Morton

(Address) 1103 Mc Culloh St.

15 Filed C. HAMPSON JONES, M. D. Registrar

4/1/ 1927 Per IRF

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) March 31 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Fracture of skull (accidental)

for minutes (duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) automobile accident

(duration) 1 yrs. .....mos. .....ds.

(Signed) J. T. Hennessy M. D. (Coroner)

4/1/ 1927 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. Date of Burial April 2 1927

20 UNDERTAKER Daniel Carter Bear ADDRESS 916

Spec.—12-4-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20804

## CERTIFICATE OF DEATH.

22-3031

E 20804

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. ) Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Stewart

(a) RESIDENCE NO. Friendly Inn St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1905

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 21 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town)

(State or country) North Carolina

PARENTS

10 NAME OF FATHER Robert Stewart

11 BIRTHPLACE OF FATHER (city or town)

(State or country) NorthCarolina

12 MAIDEN NAME OF MOTHER Partharuia ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) North Carolina

14 Informant Hospital Records

(Address) C. HAMPSON JONES, M.D.

2 1927 Per Registrar

1222

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

March 30, 1927

17

I HEREBY CERTIFY, That I attended deceased from Nov. 17 19 26 to March 30, 19 27,

that I last saw him alive on March 30, 19 27,

and that death occurred, on the date stated above, at 6 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. Gattens, M.D.

3-31-27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

UNIVERSITY OF MARYLAND

20 UNDERTAKER — ADDRESS

Commissioner Health

APR 2 - 1927

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20805

CERTIFICATE OF DEATH.

129 E 20805

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. _____ St. 22-30 Ward)

2-FULL NAME Ben Rosemary

(a) RESIDENCE NO. 117 W. Barre St St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred - yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | ? |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1857

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 70 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Texas

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town)

(State or country) N. Y.

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) N. Y.

14 Informant

(Address) ~~Ricardo~~ C. HAMPSON JONES, M. D.

15 Filed _____ 19 ____ Registrar

1223

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29 1927

17

I HEREBY CERTIFY, That I attended deceased from October 17, 1925, to March 29, 1927, that I last saw him alive on March 29, 1927, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Arterial Sclerosis

Chronic Nephritis

(duration) ? yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) ____ yrs. 6 mos. ____ ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Laboratory

(Signed) A. Cooper Leavitt, M. D.

April 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 19

20 UNDERTAKER ADDRESS

BALTIMORE CITY HOSPITALS
UNIVERSITY OF MARYLAND
Commissioner Health
APR 6 1927

Spec.—12-9-25—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20806

## CERTIFICATE OF DEATH.

× 31

E 20806

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Liviai Hospital

City of BALTIMORE: (No._____ St., 7-9 Ward)

2-FULL NAME Lena Henson

(a) RESIDENCE NO. 1761 Lamont St. Washington D.C. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occ 4 yrs. 23 ds. How long in U. S., if of foreign birth? 6 yrs. 6 mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Henson

6 DATE OF BIRTH (month, day, and year) 1870

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 57 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Lithuania

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Lithuania

14 Informant Father Henson

(Address) Washington D.C.

2 1927 C. HAMILTON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 1927

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1927, to April 2, 1927

that I last saw her alive on April 2, 1927,

and that death occurred, on the date stated above, at 12.05 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary T.B.

Arteriosclerosis

(duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Thrombosis

Cardiac failure

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Phillip Henson M. D.

4/2, 1927 (Address) Liviai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D.C. Date of Burial 4/3 1927

20 UNDERTAKER Jack Lewis ADDRESS 1439 Eckford St

Spec.—12-9-25—A Co.—200 Bks.

Phifer

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20807

CERTIFICATE OF DEATH.

35 E 20807

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospital Ward) 27-31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Phifer

(a) RESIDENCE NO. 110 Camp Ave St. 1127 Hughes St Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M | 4 Color or Race Col | 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1900

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 27 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) N. C.

(State or country)

PARENTS

10 NAME OF FATHER Thos. Phifer

11 BIRTHPLACE OF FATHER (city or town)

(State or country) N. C.

12 MAIDEN NAME OF MOTHER Mary Sumner

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) N. C.

14 Informant Hospital Records

(Address)

15 1927 C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29, 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 23, 1927, to March 29, 1927, that I last saw him alive on March 24, 1927, and that death occurred, on the date stated above, at 11:30 m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Right wrist joint 2

(Duration) 5 months ds.

CONTRIBUTORY (Secondary) Tuberculosis of Larynx

124, (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms & Bacteriological Exam.

(Signed) C. HAMPSON JONES, M. D.

, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wilmington NC Date of Burial 4/2 1927

20 UNDERTAKER Daniel Easton ADDRESS 916 Penn

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20808

CERTIFICATE OF DEATH. × 129

E 20808

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) 515 N. Gilmor St (Ward) 19-27

2-FULL NAME John T. Gardner

(a) RESIDENCE NO. Ellicott City Md. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 6 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M. | Negro | Widower |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline Gardner

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 88 | Unknown | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER John Gardner

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant (Address) Rose Biggest (Daughter) 515 N. Gilmor St

Filed 2 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 April 1st. 1927

17 I HEREBY CERTIFY, That I attended deceased from March 30th 19 27 to April 1st. 1927

that I last saw h.. 1m alive on March 31st. 1927

and that death occurred, on the date stated above, at 1.10a m.

The CAUSE OF DEATH* was as follows:

Mitral Ins. Appolexy,
Ch. Interstital Nephritis.

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Ellicott City

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Phy. Exam. Urinanyls

(Signed) Walter J. Jackson M. D.

, 19 (Address) 1631 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Western Star Cem. Patapsco Oct. 3 19 27

20 UNDERTAKER ADDRESS

Easton Sons Ellicott City

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

$ 2.35

E 20809

E 20809

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 7-13 Ward)

2-FULL NAME Jane Williams

(a) RESIDENCE NO. 1601 N. Broadway St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov. 13-1898

7 AGE: Years 28 Months 4 Days 19 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Nurse

(b) General nature of industry, business, or establishment in which employed (or employer): Hosp

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Pittston Pa

PARENTS

10 NAME OF FATHER P. J. Williams

11 BIRTHPLACE OF FATHER (city or town)

(State or country): England

12 MAIDEN NAME OF MOTHER Eliz. Williams

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Wales

14 Informant: Records

(Address): JOHNS HOPKINS HOSPITAL

15 Filed 19 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 April 2 1927

17 I HEREBY CERTIFY, That I attended deceased from March 17 1927, to April 2 1927, that I last saw her alive on April 2 1927, and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

Streptococcus Sore Throat

Cellulitis of neck. (14 days)

(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Laboratory

(Signed) W. Lindsay Kelly M. D.

4/2/1927 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Tilton Pa Date of Burial: Apr. 7 1927

20 UNDERTAKER: Joseph B. Cook

ADDRESS: 1003 N. Eutaw St

Spec.—12-9-25—A Co.—200 Bks.

Doub

HEALTH DEPARTMENT—CITY OF BALTIMORE

20810

E 20810

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

× 13 E 20810

REGISTERED NO.

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Warner Doub

(a) RESIDENCE NO. Middletown Md St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Married

6 DATE OF BIRTH (month, day, and year): Sept. 18, 1865

| 7 AGE Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|
| 61 | 11 | 14 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Insurance, Fire

(b) General nature of industry, business, or establishment in which employed (or employer): 056

(c) Name of employer

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER: Jonas A. Doub

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Md

12 MAIDEN NAME OF MOTHER: Frances Waters

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md

14 Informant

(Address) JOHNS HOPKINS HOSPITAL

Filed APR 3 1927 H. HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 2 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 28, 1927, to April 2, 1927, that I last saw him alive on April 2, 1927, and that death occurred, on the date stated above, at 5:55 p m.

The CAUSE OF DEATH* was as follows:

Pyelonephritis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? yes Date of 3/26/27

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) H C Smith, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Middletown Md Date of Burial Apr 5 1927

20 UNDERTAKER: Calvin F K Seadlee Middletown Md

South Natick Mass Elliott City Md.

Spec.—6-9-19—H. P. Co.—1000 Blks.

E 20811 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 20811

REGISTERED NO...

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1111 E Pratt st 3-5 ST. WARD)

2-FULL NAME Hyman Shemer

(a) RESIDENCE. No. 1111 E Pratt st ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? 29 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rachel

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 77 | - | - | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

D 45

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Benj Shemer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Minnie Samuels

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Frank Shemer

(Address) 20 S Exeter st.

15 Filed ... 19 ... C. HAMPTON JONES, M. D. Registrar

- 3 1927 Per ...

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1st 1927

17

I HEREBY CERTIFY, That I attended deceased from April 4 1926 to March 23rd 1927.

that I last saw him alive on March 23rd 1927.

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Physical Examination

(Signed) Saml Shydel M. D.

4/2 1927 (Address) 1635 E. Baltimore st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Hebrew Herring Run | April 3 1927 |
| 20 UNDERTAKER S Levinson Bro | ADDRESS 1127 E Balto St |

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20812

## CERTIFICATE OF DEATH

31 E 20812

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1V00 Battery Ave. St. 24-33 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME CHARLES SMITH

(a) RESIDENCE NO. 1V00 Battery Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M. | W. | Married |

5a If married, widowed, or divorced HUSBAND of MARY T. SMITH. (or) WIFE of

6 DATE OF BIRTH (month, day, and year) November 17, 1893

| 7 AGE | Years | Months | Days | IF LESS than 1 day ... hrs. or ... min.. |
|---|---|---|---|---|
| | 33 | 4 | 15 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician

(b) General nature of industry, business, or establishment in which employed (or employer) Manufacturing etc

(c) Name of employer unknown

9 BIRTHPLACE (city or town) Baltimore, Md.

(State or country)

PARENTS

10 NAME OF FATHER Charles Smith

11 BIRTHPLACE OF FATHER (City or town) Baltimore, Md.

(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Rosser

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto., Md.

14 Informant Mary T. Smith

(Address) 1V00 Battery Ave., Balto., Md.

15 Filed ... 19... CHARLES JONES, M. D.

APR 3 1927 Per ... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from ... 19... to present date 19...

that I last saw him alive on March 11, 1927.

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of lungs.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY

(Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical course and Laboratory

(Signed) Franklin S. Elliott M. D.

4/2/ 1927 (Address) 3326 Richmond Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| National Cemetery | 4/5 1927 |
| 20 UNDERTAKER | ADDRESS 1127 E. Balto. St. |
| Sol Feinman & Bro | |

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

E 20813
1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

REGISTERED NO. E 20813

City of BALTIMORE: (No. [illegible] St., 1124 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W. Henry

(a) RESIDENCE NO. 931 Madison Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, ~~Widowed~~, or ~~Divorced~~, (write the word) |
|---|---|---|
| Male | Negro | Married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1862

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 65 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labour

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer 0

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Palestine Henry

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Thompson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant

(Address) Records

15 Filed [illegible] 1927 C. HAMPSON JONES, M. D.

APR 3 1927 Per [illegible] Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30 1927

17

I HEREBY CERTIFY, That I attended deceased from March 23, 1927, to March 30, 1927, that I last saw him alive on March 30, 1927, and that death occurred, on the date stated above, at 7.15 a. m.

The CAUSE OF DEATH* was as follows:

Cortical Sclerosis,
Central Haemorrhage (duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 4 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Laboratory

(Signed) C. Hooper Leavell, M. D.

April, 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Date of Burial 4/3/1927

20 UNDERTAKER John H Toadvine ADDRESS 1027 Hanover St

Spec—12-23-21—E.B.R.S.—400 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20814
1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

90

E 20814
Registered No.

City of BALTIMORE: (No. 607 N. Luzerne ave. St., 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara Ella Ryan

(a) Residence No. 607 N Luzerne Ave St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas S. Ryan

6-DATE OF BIRTH (month, day and year) Sept 1-1873

7-AGE 53 yrs. 6 mos. 30 ds.

If LESS than 1 day, ....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) 37

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore
(State or Country) Md.

PARENTS.

10-NAME OF FATHER, Henry S. Taylor

11-BIRTHPLACE OF FATHER (city or town) Baltimore Md
(State or Country)

12-MAIDEN NAME OF MOTHER, Euphemia Myers

13-BIRTHPLACE OF MOTHER (city or town) Baltimore Md
(State or Country)

14-
(Informant) Henry Ryan
(Address) 1619 Lamont Ave

15-
Filed APR 3 1927 (192) HAMPSON JONES, M. D.
Registrar.
By P.H.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 3-31-27

I HEREBY CERTIFY, That I attended deceased from 3-15 1927 to 3/31 1927
that I last saw h[illegible] alive on 3/31 1927
and that death occurred, on the date stated above, at 7 P.M.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage X
Arteriosclerosis
(Duration) yrs. 6 mos. ds

CONTRIBUTORY (Secondary) Myocardial Degeneration
(Duration) yrs. mos. 2 ds

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) David Miller M. D.
4/1, 1927 (Address) 1420 Bolton

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

| 19-PLACE OF BURIAL, CREMATION OR REMOVAL. | DATE OF BURIAL. |
|---|---|
| Greenmount Cemetery | Apr 4 1927 |
| 20-UNDERTAKER. | ADDRESS |
| Jas C Miller & Sr | 2334 Eutaw |

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

67-901

E 20815

## CERTIFICATE OF DEATH.

E 20815

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2328 Jefferson St. 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Williams

(a) RESIDENCE NO. 2328 Jefferson St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hannah Williams

6 DATE OF BIRTH (month, day, and year): Feb 29-1880

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 47 | 1 | 3 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lead Burner.

(b) General nature of industry, business, or establishment in which employed (or employer): Co

(c) Name of employer

9 BIRTHPLACE (city or town): South Wales

(State or country): England.

PARENTS

10 NAME OF FATHER: David Williams

11 BIRTHPLACE OF FATHER (city or town)

(State or country): England.

12 MAIDEN NAME OF MOTHER: Mary Jones

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): England.

14 Informant: Hannah Williams

(Address): 2328 Jefferson St

15 Filed APR 3 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH, (month, day, and year) 19

April 1, 1927

17

I HEREBY CERTIFY, That I attended deceased from Nov 1, 1926, to April 1, 1927, that I last saw him alive on April 1, 1927, and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Chronic Lead Poisoning)

(duration) 1 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Bronchio-pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical signs

(Signed) Vincent V. Costa M. D.

, 19 (Address) 845 W. Patterson Pk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

Date of Burial: Apr 4 1927

20 UNDERTAKER: Mrs C. Keller & Son

ADDRESS: 2334 Jefferson St

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

159-001

E 20816

## CERTIFICATE OF DEATH.

E 20816

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2308 E. Monument St. 7-12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant. George M. & Minnie Brom

(a) RESIDENCE NO. 2308 E. Monument St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Baby

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 31-27.

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | | | 2. | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER George M. Brom

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore County

12 MAIDEN NAME OF MOTHER Minnie Habla

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Md.

14 Informant George M. Brom

(Address) 2308 E. Monument St

15 Filed ..... 19 ..... Registrar

APR 3 1927 Per .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 - 1927 19

17

I HEREBY CERTIFY, That I attended deceased from March 31, 1927, to April 2, 1927, that I last saw h[illegible] alive on April 2, 1927, and that death occurred, on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH* was as follows:

Influenza Pneumonia.

(duration) yrs. mos. 1 3/4 ds.

CONTRIBUTORY (Secondary) Hypertrophied Congenital (Pontine Dyslocus)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. B. Lemmon, M. D.

April 3, 1927 (Address) 718 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn County Date of Burial: April 4 1927.

20 UNDERTAKER: Chas E. Tuiler & Son ADDRESS: 2331 Jefferson

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

101-0,01

E 20817

1-PLACE OF DEATH

E 20817

REGISTERED NO.

City of BALTIMORE: (No. 1006 N. Sharp St., 23-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Ringgold

(a) RESIDENCE NO. 1006 N. Sharp St. Ward 23

(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | Col. | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Ringgold

6 DATE OF BIRTH (month, day, and year) Mch 25th 1884

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|---|
| | 42 | 4 | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur 23

(b) General nature of industry, business, or establishment in which employed (or employer) Transfer Co.

(c) Name of employer Allen & Bell

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER Edw. Ringgold

11 BIRTHPLACE OF FATHER (City or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Mary L. Butler

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Edw. Ringgold (Address) 1006 N. Sharp St.

15 Filed APR 2 1927 19 C. HAWSON JONES, M. D. Registrar

Per K.R.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/1/ 1927

17 I HEREBY CERTIFY, That I attended deceased from 3/28/ 1927 to 4/1/ 1927

that I last saw him alive on 4/1/ 1927

and that death occurred, on the date stated above, at 6:10 P.m.

The CAUSE OF DEATH* was as follows:

Double Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

Remote (duration) about yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Ben Bowers M. D.

4/1/ 1927 (Address) 908 N. Sharp St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion — Date of Burial April 1 1927

20 UNDERTAKER A. L. Parham — ADDRESS 1216 N. Sharp St

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20818

## CERTIFICATE OF DEATH.

99-001 E 20818

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hospital (ST. OR WARD)

REGISTERED NO. 4629

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilbur Harrison

(a) RESIDENCE NO. 336 S. Bruce ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 41 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | M |

a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Hallie R. Harrison

DATE OF BIRTH (month, day, and year) Oct. 12th 1889

| AGE | Years | Months | Days 20 | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 37 | 5 | 21 | |

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Auto Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Kent Co. Md. (State or country)

10 NAME OF FATHER James Oliver Harrison

11 BIRTHPLACE OF FATHER (city or town) Kent Co. Md. (State or country)

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) Kent Co. Md. (State or country)

Informant Hallie R. Harrison

(Address) 336 S. Bruce St.

Filed 3 1927, 19

C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 26 .1927. to April 2 .1927.

that I last saw him alive on April 2 .1927.

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Septicemia (Cerebral abscess)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 2-26-27

Was there an autopsy? No 3-17-27

What test confirmed diagnosis? Clinical

(Signed) H R. McCamish, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Mt. Olivet Cemetry | April 4th 1927 |
| 20 UNDERTAKER Wilbur W. Shivers. | ADDRESS 1018 Edmondson Ave. |

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20819

## CERTIFICATE OF DEATH

× 29 E 20819

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. 4-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raymond Lape

(a) RESIDENCE NO. Forest Md St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred / yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Not known

7 AGE: Years 27 Months Days IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Harford Co, Md

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Hospital records

(Address)

15 Filed APR 3 1927 19 HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-1 19 27

17 I HEREBY CERTIFY, That I attended deceased from 3-30 19 27 to 4-1 19 27

that I last saw him alive on 4-1 19 27

and that death occurred, on the date stated above, at 12:30A m.

The CAUSE OF DEATH* was as follows:

Acute tetanus

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secandary) Acute contrac Jaw Cause

(duration) yrs. mos. ½ ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Patient's physical findings

(Signed) Herbert R. Thiess M. D.

4-1 19 27 (Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pleasant View Forest Md — Date of Burial 4/3/27

20 UNDERTAKER: Samuel Hemsley — ADDRESS 617 Eutaw

Spec.—1-10-21—M&T—1500 Bks.

E 20820

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129 E 20820

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 739 W Dolphin ST. 17-23 WARD)

2-FULL NAME Robert J Overton

(a) RESIDENCE NO. 739 W Dolphin ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Overton mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Victoria Overton

6 DATE OF BIRTH (month, day, and year) 1878

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 49 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter Worker

(b) General nature of industry, business, or establishment in which employed (or employer) B

(c) Name of employer Bald Eagle 670

9 BIRTHPLACE (city or town) Boydton

(State or country) Kentucky

PARENTS

10 NAME OF FATHER George Overton

11 BIRTHPLACE OF FATHER (city or town) Ky

(State or country) Cockeysville

12 MAIDEN NAME OF MOTHER Williamson

13 BIRTHPLACE OF MOTHER (city or town) Ky

(State or country)

14 Informant Victoria Overton.

(Address) 739 W Dolphin

15 Filed APR - 3 1927, 19 C. HAMPSON JONES, M. D.

Per Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 31 1927

17

I HEREBY CERTIFY, That I attended deceased from Dec 15 1926, to Mar 31 1927,

that I last saw h— alive on Mar 31, 1927,

and that death occurred, on the date stated above, at 12 P m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous nephritis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia Edema pleuritic effusion (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Bernard J. Grant, M. D.

1927 (Address) 101 Mosher Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL Apr 4 1927

20 UNDERTAKER Samuel B Hemsley — ADDRESS 578 E Biddle

Spec.—1-12-23—M&T—500 Bks.

E 20821

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

27-002

27 E 20821

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3031 Hudson ST. 1-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Luis

(a) RESIDENCE No. 3031 Hudson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ( yrs 43 ) mos ds. How long in U. S., if of foreign birth? 7 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W. | Widower |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Luis

6 DATE OF BIRTH (month, day, and year) March 22 1857

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 70 | | 9 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Joseph Luis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Russy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Emma Luis

(Address) 3031 Hudson

15 Filed 19 Per Registrar

C. HAMPSON JONES, M. D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31 1927

17 I HEREBY CERTIFY, That I attended deceased from March 20 . 1927 . to March 28 . 1927 .

that I last saw h[illegible] alive on March 28 . 1927

and that death occurred, on the date stated above, at 1 a . m.

The CAUSE OF DEATH* was as follows:

Marasmus Senilis

arteriosclerosis

about (duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Asthma Bronchialis

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Joseph M. Rosenblatt M. D.

3/31 . 1927 (Address) 3018 Donnell St, Balto, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ft. Mc Henry — DATE OF BURIAL April 7 1927

20 UNDERTAKER Martin H. E. Deppe — ADDRESS 325 Ave

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20822

## CERTIFICATE OF DEATH.

74 001

E 20822

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 806 S. 7th St. (WARD) 26-37

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Brunner

(a) RESIDENCE NO. 806 S. 7th St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Adolph Brunner

6 DATE OF BIRTH (month, day, and year) Nov. 23-1860

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 66 | 4 | 8 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna

PARENTS

10 NAME OF FATHER John Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant (Address) Mrs. Wm. Fusz 806 S. 7th St.

15 Filed APR 3 1927 19 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1 1927

17 I HEREBY CERTIFY, That I attended deceased from 3/30 1927 to 4/1 1927

that I last saw her alive on 3/31/27 19

and that death occurred, on the date stated above, at 1:30 A m

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) R A Reppelmeyer M. D.

4/1 1927 (Address) 2464 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Matthews Cem DATE OF BURIAL apr 4 1927

20 UNDERTAKER Zirkle & Zirkle ADDRESS 1739 E. Eager

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20823

## CERTIFICATE OF DEATH.

11-001 E 20823

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2074 E. 39th. St. Ward) 13-57

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John F. Forrester, Sr.

(a) RESIDENCE No. 2074 E. 39th St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. — mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write this word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 18-1922

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 5 | — | 14 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John F. Forrester

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret R. Fink

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant John F. Forrester

(Address) 2074 E. 39th St.

15 Filed APR - 3 1927 H. HAMPTON JONES, M. D. Registrar

Per —

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 - 1927.

17 I HEREBY CERTIFY, That I attended deceased from March 26th, 19 27, to April 2nd, 19 27.

that I last saw h[illegible] alive on April 1st, 19 27.

and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Toxic hepatitis with complete jaundice

(duration) yrs. 1 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical findings

(Signed) T. A. Fulton, M. D.

Apr. 3, 1927 (Address) 3615 Foster Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sinai Ridge — DATE OF BURIAL April 4 1927

20 UNDERTAKER Horace F. Burgee — ADDRESS 1821 Falls Rd.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20824

## CERTIFICATE OF DEATH.

188-001

E 20824

1-PLACE OF DEATH

City of BALTIMORE: (No.) Colonial Hosp St., 15-58 Ward

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bernard Kemich

(a) RESIDENCE NO. 3736 Fayerda ave St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 6 mos. ds. How long in U. S., if of foreign birth? 6 yrs. 6 mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10/14 1910

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 16 | 5 | 18 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER Joseph Kemich

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Rose Ruden

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Bernard Kemich

(Address) 3736 Fayerda ave

15 Filed APR 3 1927 C. HAMPSON JONES, M. D. Registrar

Per KK

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull & R.R. accident (struck by engine), (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. J. Kenney, M. D. (Coroner)

(Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ....mos., ....ds. In the State ....yrs., ....mos., ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt Carmel Date of Burial 4/3 192 7

20 UNDERTAKER Jack Lewis ADDRESS 1439 E Balto St

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20825

## CERTIFICATE OF DEATH

90

E 20825 REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2305 Callow Ave. St. 13-39 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Sackerman.

(a) RESIDENCE NO. 2305 Callow Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Hannah Sackerman.

6 DATE OF BIRTH (month, day, and year) Sept. 15th. 1849.

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|---|
| | 77 | 6 | 17 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Md.

PARENTS

10 NAME OF FATHER Louis Sackerman.

11 BIRTHPLACE OF FATHER (City or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mrs. Hannah Sackerman.
(Address) 2305 Callow Ave.

15 Filed C. HAMPSON JONES, M. D.
R - 3 1927 By ..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2, 1927.

17 I HEREBY CERTIFY, That I attended deceased from Jan 15 1926 to Apr 2 1927, that I last saw h[illegible] alive on Apr 1 1927, and that death occurred, on the date stated above, at 3.30 A. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation
Secondary
(duration) yrs. mos. ds.

CONTRIBUTORY Myocarditis
(Secondary)
(duration) yrs. 16 mos. ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) Howard Kahn M. D.
. 19 (Address) 2027 West Pratt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship Cem. Date of Burial: 4/3/ 1927

20 UNDERTAKER: David Sondheim ADDRESS 115 20 W mt. Royal Ave

Very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20826

## CERTIFICATE OF DEATH

31 E 20826

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 2635 Hudson St St. 1-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam Poznaniak

(a) RESIDENCE NO. 2635 Hudson St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 10 1892

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 34 | 8 | 21 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Pile Driver 5 6

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto Md

PARENTS

10 NAME OF FATHER Frank Poznaniak

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Magdalena Lijewski

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Magdalena Poznaniak

(Address) 2635 Hudson St

15 Filed APR - 3 1927 19 C. HAMILTON JONES M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 March 31 1927

17 I HEREBY CERTIFY, That I attended deceased from October 10, 1926, to March 31, 1927, that I last saw him alive on March 31, 1927, and that death occurred, on the date stated above, at 11 45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Pulm. T-B.

(duration) Ca 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. Jarmoszkiewicz M. D.

4/2, 1927 (Address) 2431 Fait Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Holy Rosary Cem | April 5 1927 |

20 UNDERTAKER John W. Weber ADDRESS 1803 Bank St

Spec.—6-9-19—H. P. Co.—1000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20827

## CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 646 W. Fairmount Ave. ST. H-25 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Aloysius Savage

(a) RESIDENCE. NO. 646 W. Fairmount Ave ST., ..... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | Colored | Widower |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lilla Savage

6 DATE OF BIRTH (month, day, and year) Aug. 31, 1894

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 32 | 7 | 24 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Contractor

9 BIRTHPLACE (city or town) Washington, D.C.
(State or country)

PARENTS

10 NAME OF FATHER Hamilton Savage

11 BIRTHPLACE OF FATHER (city or town) Washington D.C.
(State or country)

12 MAIDEN NAME OF MOTHER Kate Martin

13 BIRTHPLACE OF MOTHER (city or town) Washington D.C.
(State or country)

14 Informant Hester Mitchell
(Address) 646 W. Fairmount Ave.

15 Filed APR 4 1927, 19 H. FRANKLIN JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1, 1927

17 I HEREBY CERTIFY, That I attended deceased from March 19, 1927, to April 1, 1927, that I last saw him alive on April 1, 1927, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) John D. Dunn, M. D.

4/2, 1927 (Address) 1507 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Washington D.C. | April 2 1927 |

20 UNDERTAKER [illegible]

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20828

## CERTIFICATE OF DEATH

98 E. 20828

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 2901 St Paul's St. 12-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George N. Ward.

(a) RESIDENCE NO. 2901 St. Paul's St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widower |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Adah F. Ward.

6 DATE OF BIRTH (month, day, and year) August 24 1843.

| 7 AGE | Years | Months | Days |
|---|---|---|---|
| | 83. | 7 | 8 |

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grand Secretary of Lodge

(b) General nature of industry, business, or establishment in which employed (or employer) Lodge Work

(c) Name of employer I. O. O. F.

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER John Ward

11 BIRTHPLACE OF FATHER (City or town)

(State or country) England

12 MAIDEN NAME OF MOTHER Eliza L. Gibson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Md.

14 Informant Mrs. Grace N. Hayne

(Address) 2901 St Paul St

15 Filed R - 4 1927 C. HAMPSON JONES, M. D. Registrar

per RK

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1st 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar. 15 1921 to April 1. 1921

that I last saw h.... alive on April 1. 1921

and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation.

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Laryngitis old age.

(duration) ..... yrs. ..... mos. 10 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Herbert S Blake M. D.

4/2. 1927 (Address) 1014 N. Lafayette Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Grand Lodge Elkridge

Date of Burial Apr 4 1927

20 UNDERTAKER Lord & Cook

ADDRESS 1003 N. Eutaw St.

Spec.—1-10-21—M&T—1500 Bks.

E 20829

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

X 86-001

E 20829

1-PLACE OF DEATH Maryland General Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ) ST., 11-24 WARD)

2-FULL NAME Ruth V. Burgoon

(a) RESIDENCE NO. Beechfield Ave, Cday. Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred +2? yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 26, 1914

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 12 | 4 | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto, Md.
(State or country)

PARENTS

10 NAME OF FATHER John W. Burgoon

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ind.

12 MAIDEN NAME OF MOTHER Edith Parker

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Hospital Record.
(Address)

15 Date APR - 4 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3 1927

17

I HEREBY CERTIFY, That I attended deceased from March 29, 19 27 to April 3, 19 27.

that I last saw h[illegible] alive on April 3, 19 27,

and that death occurred, on the date stated above, at 7 45 P m.

The CAUSE OF DEATH* was as follows:

Acute Suppurating Otitis Media

Acute Mastoiditis

(duration) yrs. mos 16? ds.

CONTRIBUTORY (Secondary) Septicemia - L. Lateral Sinus Thrombosis (duration) yrs. mos. 10? ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes. Date of 3/29/27

Was there an autopsy? No.

What test confirmed diagnosis? Clinical.

(Signed) [signature], M. D.

4/3, 19 27 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL Apr. 6, 1927

UNDERTAKER Joseph D Cook ADDRESS 1003 N Calvert St

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 20830

129 E 20830

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 3908 Belle Ave. St., 15-63 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Seth H. Ehlers

(a) RESIDENCE NO. 3908 Belle Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillie J. Ehlers

6 DATE OF BIRTH (month, day, and year) October, 5th. 1866

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..hrs. or ..min.. |
|---|---|---|---|---|
| | 60 | 5 | 29 28 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 166

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Co.

(State or country) Md.

PARENTS

10 NAME OF FATHER J. Henry Ehlers

11 BIRTHPLACE OF FATHER (City or town) Baltimore

(State or country) Md.

12 MAIDEN NAME OF MOTHER Ruth Elizabeth Holbrook

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co.

(State or country) Md.

14 Informant Dr. J H. Ehlers

(Address) Calvert Bldg.

15 Filed APR 4 1927, 19.. WILLIAM H. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April, 3rd. 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct, 1926, to April 3, 1927, that I last saw h~~im~~ alive on April 3, 1927, and that death occurred, on the date stated above, at 4.25 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease - Chronic Nephritis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Embolism

(duration) yrs. 4 mos. ds.

18 Where was disease contracted

if not at place of death? -

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? P. E.

(Signed) John S. Bishop, M. D.

. 19 (Address) 930 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery.

Date of Burial 4/6 1927

20 UNDERTAKER Joseph B Cook

ADDRESS 1008 W Balt

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 20831

## CERTIFICATE OF DEATH

E 20831

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 713 St Peters St. 21-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nicholas Hartman

(a) RESIDENCE NO. 713 St Peters St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 105 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Matilda Hartman

6 DATE OF BIRTH (month, day, and year): Mar. 1817

7 AGE: Years 110 Months 0 Days 0

IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Boatman

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ohio

PARENTS

10 NAME OF FATHER: John Hartman

11 BIRTHPLACE OF FATHER (City or town) (State or country): Ohio

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs Ella Gregor (Address) 713 St Peters St.

15 Filed ....19.... C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: April 1 - 27

17 I HEREBY CERTIFY, That I attended deceased from March 31, 1927, to April 1, 1927, that I last saw him alive on March 31, 1927, and that death occurred, on the date stated above, at 10.30 a. m.

The CAUSE OF DEATH* was as follows:

Intestinal Hemmorrage

(duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas. Wolfe, M. D.

4/2, 1927 (Address) 321 E. Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cem.

Date of Burial: 4/4 1927

20 UNDERTAKER: Margaret E. Flynn

ADDRESS 1427 Eutaw

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20832

## CERTIFICATE OF DEATH.

100-001

E 20832

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 128 Elm St Curtis Bay Md. ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Andrew Raska

(a) RESIDENCE No. 128 Elm ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 15 - 1927

7 AGE — Years: — Months: 1 Days: 18 If LESS than 1 day, hrs. or min.: 17

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Curtis Bay Balto Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Anna Raska

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Curtis Bay Balto Md.

14 Informant: Anna Raska

(Address) 128 Elm St

Filed 4 1927 C. HAMPTON JONES, M. D. Registrar

Per RHC

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 - 1927

17 I HEREBY CERTIFY, That I attended deceased from March 30, 1927, to April 2, 1927, that I last saw him alive on April 2 - 1927, and that death occurred, on the date stated above, at 1145A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) 1 yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Dr GW Kennard, M. D.

4-2, 1927 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross C.A.Co

DATE OF BURIAL: 4/4 1927

20 UNDERTAKER: Margaret J. Flynn

ADDRESS 1422 Light St

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20833

## CERTIFICATE OF DEATH.

179

E 20833

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hospital St., 15-21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosalie Allen

(a) RESIDENCE NO. 1428 N. Vincent St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced. (write the word): Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 13-1925

7 AGE: Years 1 Months 6 Days 17 (16) IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Va

PARENTS

10 NAME OF FATHER Benjiman Allen

11 BIRTHPLACE OF FATHER (city or town)

(State or country) S. Carolina

12 MAIDEN NAME OF MOTHER Mildred Turner

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Benjiman Allen

(Address) 1428 Vincent

15 Filed ....., 19.... C. HAMPSON JONES, M. D.

4 1927 Per ..... Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Second degree burns of body, clothing caught fire from lighting (accidental) (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Burns Pneumonia

(duration) yrs. mos. ds.

(Signed) C. T. Hampson Jones M. D.

(Coroner)

April 2, 1927 (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Date of Burial Apr 6 19 27

20 UNDERTAKER Franklin W Leitz ADDRESS 709 W 33rd St

Spec.—12-9-25—A Co.—200 Bks.

Dietiker

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

20834

## CERTIFICATE OF DEATH.

E 20834

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St. 4-1 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Dietiker

(a) RESIDENCE NO. 914 - E. Fayette St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Philip Dietiker

6 DATE OF BIRTH (month, day, and year) 1888

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| 39 | 39 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Harry Street

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Ellyfritch

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant

(Address)

Records

C. HARRISON JONES, M. D.

15 Filed APR - 4 1927 Per [redacted] Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 1927

17 I HEREBY CERTIFY, That I attended deceased from March 31, 1927, to April 2, 1927, that I last saw h[redacted] alive on April 1, 1927, and that death occurred, on the date stated above, at 1:45 A m.

The CAUSE OF DEATH* was as follows:

Resolving Bronchopneumonia

(duration) ....yrs. ....mos. ? ds.

CONTRIBUTORY (Secondary) Empyema

(duration) ....yrs. ....mos. ? ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? general & laboratory

(Signed) R. Thorpe Lint, M. D.

(Address) [redacted] April 2 1927

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cemetery Baltimore Md. Date of Burial April 5 1927

20 UNDERTAKER Henry Hoerdt Son ADDRESS 1301 E Eager St

Spec.—12-9-25—A Co.—200 Bks.

E 20835

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 20835
REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. JOHNS HOPKINS HOSP St., 18-76 Ward)

2-FULL NAME Ruby Jones

(a) RESIDENCE NO. 837 W. Lexington St. Baltimore

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 10-31-26

7 AGE: Years 4 Mos 5 Days 1 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: nr

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore City (State or country) Maryland

10 NAME OF FATHER Charles Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Rosy White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Georgia

PARENTS

14 Informant Records (Address) JOHNS HOPKINS HOSP

15 Filed APR-4 1927 HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2-1927

17 I HEREBY CERTIFY, That I attended deceased from March 29, 1927, to April 2, 1927, that I last saw h Dec alive on April 2, 1927, and that death occurred, on the date stated above, at 12 P m.

The CAUSE OF DEATH* was as follows: Tuberculous meningitis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory Findings

(Signed) H Brown, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: W Cubamon Date of Burial: April 4 1927

20 UNDERTAKER: James L Curtis ADDRESS 716 Bond

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20836

## CERTIFICATE OF DEATH.

1932

E 20836

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 710 Forest ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John T. Fahey Jr.

(a) RESIDENCE NO. 710 Forest ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Child

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year): April 2, 1924

7 AGE — Years: 2 — Months: 6 — Days: 1 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: John T. Fahey Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Ellen E. Bouchet

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant (Mother) Ellen E. Fahey. (Address) 710 Forest St.

15 Filed [illegible] 4 1927 HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 3 1927

17 I HEREBY CERTIFY, That I attended deceased from March 30th 1927 to April 3rd 1927

that I last saw h alive on April 2nd 1927

and that death occurred, on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary): Exhaustion

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) P E Fahey, M. D.

(Address) 710 W Forest Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| New Cathedral Cemetery | April 5 1927 |
| 20 UNDERTAKER | ADDRESS |
| Edmund W. Coppelin | 124 E. Eager St. |

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

49 E 20837

E 20837

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 604 Cook Row St. 1866 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William C. Appleby

(a) RESIDENCE NO. 604 Cook Row St. Ward 45th yrs.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: A. Edith Appleby

6 DATE OF BIRTH (month, day, and year): June 17th 1848

7 AGE: Years 78 Months 9 Days 15 IF LESS than 1 day ... hrs. or ... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Nursery Man

(b) General nature of Industry, business, or establishment in which employed (or employer): 086

(c) Name of employer

9 BIRTHPLACE (city or town): Yorkshire

(State or country): England

PARENTS

10 NAME OF FATHER: Samuel Appleby

11 BIRTHPLACE OF FATHER (City or town)

(State or country): England

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): England

14 Informant: A. Edith Appleby

(Address): 604 Cook Row

15 Filed ..., 19 ...

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr. 2 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1926 to Apr. 2, 1927

that I last saw h[illegible] alive on Apr 2 1927

and that death occurred, on the date stated above, at 10 30 P.M.

The CAUSE OF DEATH* was as follows: Cancer of Prostate Gland

(duration) 7 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. Hamilton M. D.

, 19 (Address) 1340 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cmtry Date of Burial: April 5th 1927

20 UNDERTAKER: Wilson W. Shriver ADDRESS: 518 Edmondson Ave

very important. See instructions on back of certificate.

C. HAMPSON JONES, M. D.

George C Scobie (See Letter)

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20838

CERTIFICATE OF DEATH

E 20838

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Union Memorial Hospital St. 11-15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Charles Scobie.
George C.

(a) RESIDENCE NO. Charles Apartment St. Ward Balt.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M. | W. | Married. |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Charles Scobie.

6 DATE OF BIRTH (month, day, and year) Jan 16 1884

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 43 | 2 | 17 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steel Burner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Scotland
(State or country)

PARENTS

10 NAME OF FATHER Mr George Scobie

11 BIRTHPLACE OF FATHER (City or town)
(State or country) Scotland

12 MAIDEN NAME OF MOTHER Marika Scobie

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Scotland

Informant Union Mem. Hospital
(Address) 33 St. & Calvert

led 4 1927 19 M.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927
April 3,

17 I HEREBY CERTIFY, That I attended deceased from March 27, 1927, to April 3, 1927, that I last saw h. alive on April 2, 1927, and that death occurred, on the date stated above, at 3.30 a. m.

The CAUSE OF DEATH* was as follows:
Appendicitis with peritonitis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted
If not at place of death? At Home

Did an operation precede death? Yes Date of March 29 1927

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Raymond F. Johnston, M. D.

, 19 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New York City. N.Y.

Date of Burial 4-4 1927

20 UNDERTAKER Henry W. Jenkins & Co

ADDRESS Richard McCulloh

Spcg.—12-9-25—A Co.—200 Bks.

E 20839

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 20839

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Croncher

(a) RESIDENCE NO. Govanstown, Md St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Baby

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1-30-27

7 AGE — Years: — Months: 2 mo. Days: 4 d. IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country) Md

PARENTS

10 NAME OF FATHER John Croncher

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Md

12 MAIDEN NAME OF MOTHER Catherine Hughes

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Pa

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed APR - 4 1927 HAMPSON JONES, M. D. Registrar

Date

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Lipus 2 1927.

17

I HEREBY CERTIFY, That I attended deceased from Feb 15 1927, to April 2, 1927

that I last saw h..... alive on ....., 19.....,

and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Primary Broncho

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Prematurity

(duration) ..... yrs. Lifetime ds.

18 Where was disease contracted

If not at place of death!

Did an operation precede death? Date of

Was there an autopsy? yes.

What test confirmed diagnosis? autopsy

(Signed) H. E. Handley, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cem. Date of Burial April 4 1927

UNDERTAKER: Lilly & Fiske ADDRESS 403 S. Wolfe St.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

38 E 20840

E 120840 DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. Baltimore City Hospitals St. B-5 Ward)

2-FULL NAME Isaac Foster

(a) RESIDENCE NO. 816 E. Pratt st. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | Widower |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1863 ?

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| 64 | 63 ? | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER Wallace Foster

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Sarah Braxton

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant Hospital Records

(Address)

15 Filed ....., 19..... HAMPSON JONES, M. D. Registrar

Fee: N.C.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Dec. 22, 1926, to April 1, 1927,

that I last saw him alive on April 1, 1927,

and that death occurred, on the date stated above, at 5.30 a. m.

The CAUSE OF DEATH was as follows:

Gastric Ulcer

Syphilis Cirrhosis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? Yes Autopsy

What test confirmed diagnosis?

(Signed) W. E. Gallick, M. D.

4-1-27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Cemetery Date of Burial April 4, 1927

20 UNDERTAKER Mrs. Katie R. Williams ADDRESS 322 N. Schroeder St.

APR 4 1927

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20841

101-001

E 20841

## CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. [redacted] St., 26 Ward)

2-FULL NAME Edna E. Reese

(a) RESIDENCE NO. 3204 Esther Place St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James A. Reese

6 DATE OF BIRTH (month, day, and year) 1888

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 39 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Frederick H. White

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant

(Address) Records

BALTIMORE CITY HOSPITALS

15 Filed APR 4 1927 19 H. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 1927

17

I HEREBY CERTIFY, That I attended deceased from March 27, 1927, to April 2, 1927, that I last saw h.. alive on April 1, 1927, and that death occurred, on the date stated above, at 5.00 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) .....yrs. .....mos. 9 ds.

CONTRIBUTORY .....
(Secondary)

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? General & Laboratory

(Signed) R. Hoppin Smith, M. D.

April 2 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Oak Lawn Cem. | April 5th 1927 |

20 UNDERTAKER Geo M. Fink & Son ADDRESS 811 N Wolfe

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20842

## CERTIFICATE OF DEATH.

E 20842

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1601 Norwood ave ST. 8-45 WARD)

2-FULL NAME Michael J Farley.

(a) RESIDENCE NO. 1601 Norwood av ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? 50 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Farley.

6 DATE OF BIRTH (month, day, and year) Oct. 13 1862

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 64 | 5 | 19 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Fireman

(b) General nature of industry, business, or establishment in which employed (or employer) Fireman

(c) Name of employer City.

9 BIRTHPLACE (city or town) (State or country) Balt. Co.

PARENTS

10 NAME OF FATHER Joseph Farley.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt. Co

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt

14 Informant Mrs Anna Farley.

(Address) 1601 Norwood ave

15 Filed 4 1927 19 [illegible] M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 1927

17 I HEREBY CERTIFY, That I attended deceased from # 3/1, 1927, to 4/2, 1927, that I last saw him alive on 4/2, 1927 and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis Degeneration

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Chronic Int. Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) David Miller, M. D.

4/4, 1927 (Address) 1500 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hoy Redmen — DATE OF BURIAL April 5 1927

20 UNDERTAKER Geo. J. Rust — ADDRESS 1735 Harford av

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20843

## CERTIFICATE OF DEATH.

178

E 20843

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Provident Hospital St., 9-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jesse Gibbs

(a) RESIDENCE NO. 1721 Spring St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) 10 | 5 | 26

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | | 5 | 26 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.

(State or country)

PARENTS

10 NAME OF FATHER Jessie Gibbs

11 BIRTHPLACE OF FATHER (city or town) Balto Md

(State or country)

12 MAIDEN NAME OF MOTHER Rosie Stokes

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto Md.

14 Informant Rosie Stokes

(Address) 1721 N Spring St

Filed APR 4 1927 C. HAMPSON JONES, M. D.

Per Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

3rd degree burns of body (Accidental)

(duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) House caught fire

(duration) ....yrs. ....mos. ....ds.

(Signed) J. C. Kennedy M. D.

(Coroner)

March 24, 1927 (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the state ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery Date of Burial 4 | 4 1927

20 UNDERTAKER George J. Ruth ADDRESS 1735 Harford Ave

Spec. -7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

132 E 20844

E 20844
1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 2646 Harlem Ave St. 16-68 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Markey Harrison

(a) RESIDENCE NO. 2646 Harlem Ave St. Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. 7 mos. 21 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~: Katherine Harrison

6 DATE OF BIRTH (month, day, and year): Aug 10, 1887

7 AGE: Years: 39 yrs | Months: 7 mo | Days: 21 da | IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Oil Salesman
(b) General nature of industry, business, or establishment In which employed (or employer): 066
(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER: Wm H. Harrison

11 BIRTHPLACE OF FATHER (City or town): Washington DC
(State or country)

12 MAIDEN NAME OF MOTHER: Ann Simmons

13 BIRTHPLACE OF MOTHER (city or town): Balto Md
(State or country)

14 Informant: Walter C Bacon
(Address): 100 E 20 Wo Ft

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar
APR 4 1927
Per .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: March 31, 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 15, 1927, to March 31, 1927, that I last saw him alive on March 31, 1927, and that death occurred, on the date stated above, at 6.05 P. m.

The CAUSE OF DEATH* was as follows:

Kidney Acute Dilation
of Heart
(duration) ..... yrs. ..... mos. 1/2 ds.

CONTRIBUTORY (Secondary): Kidney stones
(duration) ..... yrs. 6+ mos. ..... ds.

18 Where was disease contracted: C
If not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Three Acute Dilation

(Signed) Walter C Bacon M. D.
3/31/1927 (Address) 100 E 20 Wo Ft

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — Date of Burial: April 4 1927

20 UNDERTAKER: for Joerdens Son — ADDRESS: 2178 Bo

Very important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

E 20845

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 20845

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 5331 N. Lakewood Ave (Ward) 10

2-FULL NAME Anna Catherine Marshall

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 5331 N. Lakewood Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. 4 mos. 21 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm. H. Marshall

6 DATE OF BIRTH (month, day, and year): Nov 13 1846

7 AGE: Years 80 Months 4 Days 21

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Merrex

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Thuman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant (Address) Wm. H. Marshall 5331 N. Lakewood Ave

15 Filed APR - 4 1927 19 C. HAMPSON JONES, M. D. Registrar

Per LH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 3 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 21, 1927, to April 2, 1927, that I last saw h[er] alive on April 2, 1927, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) ..... yrs. 1½ mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(over)

(duration) ..... yrs. 1 mos. ..... ds.

18 Where was disease contracted

If not at place of death? 4164 W Pratt St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Beatrice Catherine M. D.

19 (Address) 1404 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

Date of Burial: Apr 6 1927

20 UNDERTAKER: Jos Joesdens Son

ADDRESS: 217 S. Pac

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

**E 20846**

## CERTIFICATE OF DEATH.

90 ✓ **E 20846**

1-PLACE OF DEATH

REGISTERED NO._____

City of BALTIMORE: (No. 22 HEMLOCK Road St. 27-43 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie L. Burns

(a) RESIDENCE NO. 22 Hemlock Road St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 2 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced (or) WIFE of: Nathan J. Burns

6 DATE OF BIRTH (month, day, and year): Jany 19/861

7 AGE — Years: 66 Months: 2 Days: 14 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Md

PARENTS

10 NAME OF FATHER Charles Dieruff

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Lutz

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Md

14 Informant Leo E. Burns

(Address) 260 Towanda Ave

15 Filed.....19..... Registrar

C. HAMPSON JONES, M. D.

Apr 1927 Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apl. 2 1927

17

I HEREBY CERTIFY, That I attended deceased from Mar 24, 1927, to Apr 2, 1927, that I last saw h.. alive on Apr 1, 1927, and that death occurred, on the date stated above, at 3 50 A m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) .....yrs. .....mos. 4 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 8 yrs. — mos. .....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) J. Edw. Talbot, M. D.

4/2, 1927 (Address) 1355 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. Date of Burial Apl 1927

20 UNDERTAKER: Harry W. Ehlen ADDRESS 1946 W. North Ave

Spec.—7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

20847

90 E 20847

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. West Roland Park (near Falls Road) St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry James Fuhrman

(a) RESIDENCE NO. West Roland Park St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Helen Jane Fuhrman

6 DATE OF BIRTH (month, day, and year) Oct 10 1855

| 7 AGE | Years | Months | Days | IF LESS than 1 day ...hrs. or ...min. |
|---|---|---|---|---|
| | 72 | 5 | 22 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman Retired

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER Henry Fuhrman

11 BIRTHPLACE OF FATHER (City or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Sarah Shaffer

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Irvin L. Fuhrman

(Address) 3624 Roland Ave.

15 Filed APR - 4 1927 16 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 April 2,

17 I HEREBY CERTIFY, That I attended deceased from March 23, 1927, to April 2, 1927, that I last saw him alive on April 1, 1927, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypocarditis, Endocarditis Chronic Nephritis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Frank H. Leach, M. D.

, 19 (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Stultz New Freedom Pa. Date of Burial April 5 1927

20 UNDERTAKER Chenoweth Son ADDRESS 341 Chestnut Ave

Very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

1975/14 E 20848

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

100-001 E 20848

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 11-15 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Gray

(a) RESIDENCE NO. 715 N. Charles St. City Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unk

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 62 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Butler

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto.

(State or country)

PARENTS

10 NAME OF FATHER: James Gray

11 BIRTHPLACE OF FATHER (city or town): Md.

(State or country)

12 MAIDEN NAME OF MOTHER: Francis Smith

13 BIRTHPLACE OF MOTHER (city or town): Md.

(State or country)

14 Informant: Friends

(Address) JOHNS HOPKINS HOSPITAL

15 Filed R-4 1927, 19 C. HARRISON

Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar. 16, 1926, to April 3, 1927, that I last saw him alive on April 3, 1927, and that death occurred, on the date stated above, at 9:20 A.M.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

Arteriosclerosis

Hypertension

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) E. Cowley Kidney, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem. Date of Burial 4-6 1927

20 UNDERTAKER: George T. A. Gibson ADDRESS 1983 Druid Hill Ave

Spec.—1-12-23—M&T—500 Blks.

E 20849

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 20849

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No.) Mrs. Jennie Robenson ST. 13-59 WARD)

2-FULL NAME 819 Whitelock St

(a) RESIDENCE NO. 819 Whitelock St ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | white | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. E. Robenson

6 DATE OF BIRTH (month, day, and year) unknown

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 60 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER not given

11 BIRTHPLACE OF FATHER (city or town) (State or country) " "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant Mr. E. Robenson (Address) 819 Whitelock St

15 Filed 4 1927, 19 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-3 1927

17 I HEREBY CERTIFY, That I attended deceased from 3-26, 1927, to 4-3, 1927, that I last saw him alive on 4-3, 1927, and that death occurred, on the date stated above, at 4:30 P m.

The CAUSE OF DEATH* was as follows:

(1) Myocarditis chronic

Nephritis chronic ? auto intoxication

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) W P H Brick M. D.

4/3, 1927 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Hebrew Cem. DATE OF BURIAL 4/4 1927

20 UNDERTAKER Jack Lewis ADDRESS 1439 Eutaw St

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20850

## CERTIFICATE OF DEATH.

75-002

E 20850

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew aged Home ST. 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosel Fisher

(a) RESIDENCE NO. 115 Aisquith St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jetta Fisher

6 DATE OF BIRTH (month, day, and year) Unk

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 70 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none old

(b) General nature of industry, business, or establishment in which employed (or employer) aged ddo

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant A. L. Fisher

(Address) 1 Eppermanhos Ave.

APR 4 1927 Filed HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/4 1927

17 I HEREBY CERTIFY, That I attended deceased from June 1927, to April 3 1927

that I last saw h[illegible] alive on [illegible] 19

and that death occurred, on the date stated above, at 5 a m

The CAUSE OF DEATH* was as follows:

Coma

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Paralysis

(duration) yrs 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible], M. D.

4/4, 1927 (Address) 30 3 E Pra

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Messrs Rem

DATE OF BURIAL 19

20 UNDERTAKER Jack Lewis 1439

ADDRESS

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20851

## CERTIFICATE OF DEATH.

11-001

REGISTERED NO. E 20851

1-PLACE OF DEATH

City of BALTIMORE: (No. 1317 N. Saratoga St., 9-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joshua Johnson

(a) RESIDENCE NO. 1317 N. Saratoga St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colrd

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Nelena Johnson

6 DATE OF BIRTH (month, day, and year): March 4 1871

7 AGE: Years 56 Months — Days 28

IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Porter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Dobler & Mudge

9 BIRTHPLACE (city or town):

(State or country): Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Unknown

14 Informant: Edna Taylor

(Address): 1319 N. Saratoga St

15 Filed: 1927 G. HAMILTON JONES, M. D. Registrar

Per

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 1st 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) and from this find that said deceased came to death (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) — yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. B. Horton M. D.

(Coroner)

(Address) Curtis Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional Space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the state ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetary — Date of Burial: April 4 1927

20 UNDERTAKER: Mr. Jesse W. Redden — ADDRESS: 436 W. Biddle St

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20852

## CERTIFICATE OF DEATH.

100E 001 ✓ 1927 67 60

100E 20852

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 14-20 Ward)

2-FULL NAME FRANK GORDON

(a) RESIDENCE NO. 15-49 Argyle Ave. Balto St. _____ Ward M

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ever yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Col | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Gordon

6 DATE OF BIRTH (month, day, and year) Feb 21 1860

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 67 | 1 | 10 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) West Va

PARENTS

10 NAME OF FATHER Thomas Gordon

11 BIRTHPLACE OF FATHER (city or town)

(State or country) West Virginia

12 MAIDEN NAME OF MOTHER Lockwood

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) West Virginia

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed APR 4 1927 16 C. HAMPSON JONES, M. D. Registrar

Per K R

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Feb 22, 1927, to April 2, 1927, that I last saw h.. alive on April 2, 1927, and that death occurred, on the date stated above, at 11.45 A.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ____ yrs. ____ mos. 5 ds.

CONTRIBUTORY (Secondary) Myocardial failure with arteriosclerosis

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted at place of death

If not at place of death

Did an operation precede death? yes Date of March 29, 1927

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) H. C. Smith, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Date of Burial Apl 6th 1927

20 UNDERTAKER Hammond E. Wright & Co. ADDRESS 1614 N. Caroline.

Spec.—1-10-21—M&T—1500 Bks.

# E 20853 HEALTH DEPARTMENT—CITY OF BALTIMORE

47 E 20853

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2808 Clifton Park Terrace (St.) 8-45 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Werner

(a) RESIDENCE NO. 2808 Clifton Park Terrace ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widow of John Werner

6 DATE OF BIRTH (month, day, and year): October 13, 1867

7 AGE: Years 59 | Months 7 | Days 28 | If LESS than 1 day, hrs. or min. 19

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: John Denhardt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Helene Wagner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Edna Werner, 2808 Clifton Pk. Ter.

15 Filed ..... 19..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (Saturday) (month, day and year): April 2 1927

17

I HEREBY CERTIFY, That I attended deceased from January 1, 1927, to April 1, 1927,

that I last saw her alive on April 2, 1927,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast, bilateral with metastases in mediastinum

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. L. Wilkinson, M. D.

4,2, 1927 (Address) A. L. Wilkinson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount

DATE OF BURIAL: 4/5 1927

20 UNDERTAKER: Philip Henry

ADDRESS 2016 Aliceanna

APR 4 1928 HAMPSON L. K. M. D.

Spec.—12-9-25—A Co.—200 Bks.

**E 20854** HEALTH DEPARTMENT—CITY OF BALTIMORE 11-001 **E 20854**

## CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 416 N. Montford St., 6-10 Ward)

2-FULL NAME Rose E. Paster

(a) RESIDENCE NO. 416 N. Montford St. Ward .....

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? 54 yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of late James T. Paster

6 DATE OF BIRTH (month, day, and year) May 22/48

7 AGE

| Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|
| 78 | 10 | 10 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) City

(State or country)

PARENTS

10 NAME OF FATHER James Jones

11 BIRTHPLACE OF FATHER (city or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Mrs Maude Bauer

(Address) 416 N. Montford a

15 Filed ..... 19 ..... Registrar

R-4132

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apl 7/27 19

17 I HEREBY CERTIFY, That I attended deceased from 3-10 19 27 to 4-7 19 27, that I last saw h alive on 4-1 19 27 and that death occurred, on the date stated above, at 2:45 m.

The CAUSE OF DEATH* was as follows:

La Grippe

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) ..... yrs. ..... mos. 14 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Finding

(Signed) J. Hurley Rupkey M. D.

19, 19 (Address) 800 N Bath Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — Date of Burial 4/5 1927

20 UNDERTAKER Philip Henry — ADDRESS 2016 Orleans St.

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20855

## CERTIFICATE OF DEATH

100-001 E 20855

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Union Memorial Hospital St. 12-49 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs David J Wilson

(a) RESIDENCE NO. Emmorton, Md. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..hrs. or ..min.. |
|---|---|---|---|---|
| | 80 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Joshua Wilson

11 BIRTHPLACE OF FATHER (City or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Rebecca Lee

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant C/O Rural
(Address) Bel Air Md

15 Filed ..., 19 C. HAMPSON JONES, M. D. Registrar

APR - 4 192 Per RK

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19
April 4. 1927

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1927, to April 4, 1927.

that I last saw h.i alive on April 3, 1927

and that death occurred, on the date stated above, at 5. a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Emmorton Md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Raymond I Johnson, M. D.

. 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Mt Carmel | April 6 1927 |

20 UNDERTAKER Howard C Malone Abingdon ADDRESS

Very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Rks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20856

## CERTIFICATE OF DEATH.

91-9 E 20856

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 10 Keene (St.) Hamilton (Ward) 43

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James B. Carroll

(a) RESIDENCE. (No.) 10 Keene (St.) Hamilton (Ward)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 3 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | W | Widower |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophie Carroll

6 DATE OF BIRTH (month, day, and year) Dec 29 1850

| 7 AGE Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|
| 76 | 3 | 5 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gardener

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Henry P. Carroll

11 BIRTHPLACE OF FATHER (city or town) (State or country) Portland Maine

12 MAIDEN NAME OF MOTHER Mary A. Stonesifer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Boston Mass.

14 Informant (Address) Mrs. Bailey Same

15 Filed 19 Registrar

C. HAMPSON JONES, M. D.

R-4 15 Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 2 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 20 1927, to Apr 2 1927.

that I last saw h alive on Mar 21 1927.

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Arterial Sclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis Palpable arteries

(Signed) Dr. H. Pearce M. D.

4/3, 1927 (Address) 2105 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Reisterstown Md | Apl. 4 1927 |
| 20 UNDERTAKER | ADDRESS |
| Wm. J. Packer Sons | Balto. Md |

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20857

## CERTIFICATE OF DEATH.

E 20857

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Baltimore Gen. Hosp. St. 15-68 45 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr John Bauer

(a) RESIDENCE NO. 2814 Brookery St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rosamond Mell (Hyland)

6 DATE OF BIRTH (month, day, and year): July 4 1877

7 AGE: Years 49 50 | Months 8 | Days 27 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Foreman 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Adam Bauer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Christina Bauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): West Baltimore Hosp Records

15 Filed APR - 4 1927 S. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/1 1927

17 I HEREBY CERTIFY, That I attended deceased from 3/27 1927, to 4/1 1927, that I last saw him alive on 4/1 1927, and that death occurred, on the date stated above, at 11.45 P m.

The CAUSE OF DEATH* was as follows: Carcinoma of Sigmoid

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary): Post operative pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 3/29/27

Was there an autopsy? no

What test confirmed diagnosis Clinical & Autopsy

(Signed) Arnold L. Jensen M. D.

4/2 1927 (Address) West Baltimore Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: April 6 1927

20 UNDERTAKER: Harry H. Nuttle

ADDRESS: 1521 W Lanvale St

Spec.—1-10-21—M&T—1500 Bks.

E 20858

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90

REGISTERED NO. E 20858

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 224 N Payson St., ST., 19-27 WARD)

2-FULL NAME Lillian Dawson,

(a) RESIDENCE NO. 224 N Payson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edwar W Dawson

6 DATE OF BIRTH (month, day, and year) Aug. 3, 1881

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 45 | 7 | 29 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Washington (State or country) D. C.

PARENTS

10 NAME OF FATHER August Plitt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothea Margold

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Edward W Dawson (Address) 224 N Payson St.

15 Filed . 19 Registrar

C. HAMPTON JONES, M. D.

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1 1927

17 I HEREBY CERTIFY, That I attended deceased from March 19, 1927, to April 1, 1927, that I last saw h alive on March 31, 1927, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Gustav Diel M. D.

(Address) 1109 Wilkens Ave

4/4, 1927

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL April 5 1927

20 UNDERTAKER Harry K Watts

ADDRESS 1531 Fremont

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 20859 HEALTH DEPARTMENT—CITY OF BALTIMORE

65-201 E 20859

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore Eye Ear Throat Hospital REGISTERED NO.

CITY OF BALTIMORE: No. Eutaw & Lanvale Sts. (ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jarratt

(a) RESIDENCE. No. 208 McMechan ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Feamle | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 14, 1897

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 29 | 6 | 20 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bookeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Everatt P. Jarratt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Lorena Partridge

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mrs. J. F. Page
(Address) 208 McMechen St.

15 Filed . 19 C. HAMPSON JONES, M. D. Registrar
4 1927 Per

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/3/27 19

17 I HEREBY CERTIFY, That I attended deceased from 3/26/27, 19, to 4/3/27, 19, that I last saw her alive on 4/3/27, 19, and that death occurred, on the date stated above, at 10:30 A m.

The CAUSE OF DEATH* was as follows:

Acute lymphatic Leukemia

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Same as primary

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Blood examination

(Signed) Mary Louise Small, M. D.

4/3, 1927 (Address) 1214 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Richmond Va., | April 6 1927 |
| 20 UNDERTAKER Harry Hubbard | ADDRESS 531 Eutaw St |

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20860

## CERTIFICATE OF DEATH.

129 E 20860

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 550 Presstman ST. 14-20 WARD)

2-FULL NAME Cornelius H. Jones

(a) RESIDENCE NO. 550 Presstman ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Fannie Arnett Jones

6 DATE OF BIRTH (month, day, and year): Jan 26. 1870

7 AGE — Years: 57 — Months: 2 — Days: 5 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Hotel Keeper

(b) General nature of industry, business, or establishment in which employed (or employer): Arlington Hotel

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Cornelius H. Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Fanny Bland

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant (Address): Mattie Nophlin 1626 W. Lafayette

Filed 4/2, 1927 C. HAMPSON JONES, M. D. Registrar

Per RAL

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 1 1927

17 I HEREBY CERTIFY, That I attended deceased from March 26, 1927 to April 1, 1927 that I last saw h[illegible] alive on April 1, 1927 and that death occurred, on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Septicaemia (Staphylococcus Pyogenes Aureus)

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis, Arteriosclerosis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1631 Pennsylvania Ave

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Diagnosis

(Signed) W. N. Wright M. D.

4/2, 1927 (Address) 1209 Presstman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem.

DATE OF BURIAL: 4/5/27

UNDERTAKER: James T. Hendley

ADDRESS: W Baltimore

Spec.—12-9-25—A Co.—200 Bks.

E 20861

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90

E 20861

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor St. 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Fowler

(a) RESIDENCE NO. Preston & Valley St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | W | Widowed |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 9th 1861

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| 65 | 66 | 3 | 24 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER David Johnson

11 BIRTHPLACE OF FATHER (city or town) Balt.

(State or country)

12 MAIDEN NAME OF MOTHER Laura Nicholls

13 BIRTHPLACE OF MOTHER (city or town) Balt.

(State or country)

14 Informant Little Sisters of the Poor

(Address) Preston & Valley Sts.

15 Filed ..... 19 ..... J. HAMPSON JONES, M. D.

Registrar

Per .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3 1927

17

I HEREBY CERTIFY, That I attended deceased from No record ....., 19....., to ....., 19.....,

that I last saw h.... alive on April 2, 1927,

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows)

Chronic Myocarditis

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY Arteriosclerosis

(Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

April 3, 1927 (Signed) F. J. Wemer, M. D.

(Address) 103 Valley St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Date of Burial Apr 4 1927

20 UNDERTAKER Bila Wiedefeld ADDRESS 714 Fremont Ave

Very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

20862 | 129E 20862

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 615 Gorsuch Avenue ST., 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachel A. Brown

(a) RESIDENCE NO. 615 Gorsuch Avenue ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. 4 mos. 10 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J. Wilson Brown

6 DATE OF BIRTH (month, day, and year) Nov. 22, 1846

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min |
|---|---|---|---|---|
| | 80 | 4 | 10 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER John Rothrock

11 BIRTHPLACE OF FATHER (city or town) York (State or country) Pa.

12 MAIDEN NAME OF MOTHER Margaret Agnew

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant J. Wilson Brown (Address) Stratford Apartments

Filed APR 4 1927 W. HAMPSON JONES, M. D. Registrar

Per RLL

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 1927

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1926, to April 2, 1927, that I last saw h alive on April 2, 1927, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Chr. Myocarditis
Chronic Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) G W Bishop, M. D.

April 4, 1927 (Address) 501 Sheridan Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Saters Burying Ground

DATE OF BURIAL 4/5 1927

20 UNDERTAKER Henry W. Mears & Son

ADDRESS 805 N. Calvert

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20863 100-001 E 20863

## CERTIFICATE OF DEATH.

REGISTERED NO. _____

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 6-9 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME John Stephenson

(a) RESIDENCE NO. 1522 Belmont Ave. Balto Md Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col-

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 23-1926

7 AGE: Years: (6 mos) Months: 7 Days: 9 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Maryland

PARENTS

10 NAME OF FATHER Willie Stephenson

11 BIRTHPLACE OF FATHER (city or town):

(State or country) North Carolina

12 MAIDEN NAME OF MOTHER Lizzie Soles

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) North Carolina

14 Informant Parents

(Address)

JOHNS HOPKINS HOSP. M. D.

15 Filed R-4 1927 H. HAMPSON JONES Registrar

Per RH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar-3, 1927, to April 2, 1927,

that I last saw h.im alive on , 1927,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Empyema.

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Tetany, Rickets, Pneumonia bronchial

(duration) yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes Date of 23 Mar 27.

Was there an autopsy? Yes.

What test confirmed diagnosis? autopsy

(Signed) W. E. Handley, M. D.

, 19 (Address) John s Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury cemetery Date of Burial April 4 1927

20 UNDERTAKER: Edward Bryan ADDRESS 631 Orleans St

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 20864 DEATH

REGISTERED 20864

City of BALTIMORE: (No. 136 Montebello Terrace St., 45 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura E Caulk

(a) RESIDENCE NO. 136 Montebello Terrace St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: David N Caulk

6 DATE OF BIRTH (month, day, and year): Sept 2. 1872

7 AGE: Years 54 Months 7 Days 1 IF LESS than 1 day ... hrs. or ... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Falls Md

PARENTS

10 NAME OF FATHER: L. Utermohle

11 BIRTHPLACE OF FATHER (City or town) (State or country): Falls Md.

12 MAIDEN NAME OF MOTHER: Kate Richey

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Falls Md

14 Informant: David N Caulk

(Address): 136 Montebello Terrace

15 Filed ... 19... Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 3 1927

17 I HEREBY CERTIFY, That I attended deceased from June ... 19 27 to Sept 3 19 27

that I last saw h... alive on Sept 3 19 27

and that death occurred, on the date stated above, at 8 15 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Myocardial Degeneration

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas Simms M. D.

9/4. 19 27 (Address) 4706 Reisterstown Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — Date of Burial: Sept 6 1927

20 UNDERTAKER: William Cook — ADDRESS: 512 E Monument

Very important. See instructions on back of certificates.

SEP - 4 1927 C. THOMPSON JONES, M. D.

Spec.–7-17-26—A Co.—200 Bks.

Fairview – B Hy + Collins

# HEALTH DEPARTMENT—CITY OF BALTIMORE

122-001

## CERTIFICATE OF DEATH

E 20865

1-PLACE OF DEATH

REGISTERED E 20865

8-16

City of BALTIMORE: (No. 2614 E Ollins St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Jones Paulett

(a) RESIDENCE NO. 2614 E. Ollins St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Pauline

6 DATE OF BIRTH (month, day, and year) June 21, 1867

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| 62 63 | 9 | 10 | 12 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Oyster

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer City

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Jones Paulett

11 BIRTHPLACE OF FATHER (City or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Mollie Kenny

13 BIRTHPLACE OF MOTHER (city or town) Ireland

(State or country)

14 Informant Pauline Paulett

(Address) 2614 E Ollins St

15 Filed APR - 4 1927 19 C. HAMPTON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1 1927

17 I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...,

that I last saw h... alive on ....., 19...,

and that death occurred, on the date stated above, at ... p. m.

The CAUSE OF DEATH* was as follows:

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY

(Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) ....., M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Park Hood | April 5 — 1927 |

20 UNDERTAKER H. M. Cole 502 E Oliver ADDRESS

Very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 20866

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20866

## CERTIFICATE OF DEATH.

161-001

12-50

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3041 Guilford Av ST.) (WARD 12)

2-FULL NAME Robert M. Hughes

(a) RESIDENCE NO. 3041 Guilford Av ST.

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 30 27

7 AGE — Years: — Months: — Days: 1 hr — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Michael Hughes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Lillie Hemmigel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): New York

14 Informant: Michael Hughes

(Address) 3041 Guilford Av

15 Filed 4 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 4 1927

17 I HEREBY CERTIFY, That I attended deceased from March 24, 1927, to April 3, 1927, that I last saw him alive on April 3, 1927, and that death occurred, on the date stated above, at 11.45 P m.

The CAUSE OF DEATH* was as follows:

Premature infant (1 mo)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter C Bacon, M. D.

4/4 1927 (Address) 1002 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dr. Main's Hampden

DATE OF BURIAL: 4-6 1927

20 UNDERTAKER: Wm. Cook

ADDRESS: 502 6 Mont

Spec.—1-12-23—M&T—500 Bks.

E 20867

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20867

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mercy Hospital

REGISTERED NO. 21

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ) ST. 3-5 WARD)

2-FULL NAME George Smith,

(a) RESIDENCE NO. 808 E Pratt St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M. | Wh. | Widower |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary

6 DATE OF BIRTH (month, day, and year) Nov 23 1850

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 76 | 10 | 11 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Geo. F. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Cath Eubert.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Christian G Smith (Address) 810 Ellwood Ave

15 Filed 4 1927, 19 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 27

17 I HEREBY CERTIFY, That I attended deceased from 4/1, 19 27, to 4/3, 19 27

that I last saw h[illegible] alive on 4/3, 19 27

and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Erysipelas

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bowel Trouble

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Pollitta, M.D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Md

DATE OF BURIAL Nov 6 1927

20 UNDERTAKER Wm Cook & Son

ADDRESS

Spec.—12-9-25—A Co.—200 Bks.

E 20868

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129 E 20868

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 742 Pine St. 17-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albt. Lousby

(a) RESIDENCE NO. 742 Pine St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie V. Lousby

6 DATE OF BIRTH (month, day, and year) January 30. 1864

7 AGE 62 Years | 8 Months 9 | Days 2 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Common Labor

(b) General nature of Industry, business, or establishment in which employed (or employer): 40

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Charles Lousby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Kitty Goods

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Sarah Goods (Address) 742 Pine St.

15 Filed APR 4 1927 C. HAMPSON JONES, M. D. Registrar Per R.H.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/2/1927

17 I HEREBY CERTIFY, That I attended deceased from March 18 1927, to April 2, 1927, that I last saw him alive on April 1, 1927, and that death occurred, on the date stated above, at 8:40 a m.

The CAUSE OF DEATH* was as follows:

Uremia

(Duration) 3 yrs. mos. days

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) several months yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) John H. Montgomery M. D.

4/2/1927 (Address) 1014 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem. Date of Burial 4/4 1927

20 UNDERTAKER Samuel L. Kirby ADDRESS 1308 Bond St.

Key important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1 29 E 20869

E 20869 PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 836 N. Fulton Ave., ST. 16-27 WARD)

2-FULL NAME Miss Kate Waltz

(a) RESIDENCE NO. 836 N. Fulton Ave., ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 28, 1857

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 70 | 1 | 3 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hagerstown, Maryland

PARENTS

10 NAME OF FATHER C. William Waltz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hagerstown, Md.

12 MAIDEN NAME OF MOTHER Amelia Stake

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Williamsport, Md.

14 Informant John W. Waltz
(Address) 2837 St. Paul St.

15 Filed ..... 19 ..... By ..... Registrar

HAMPSON JONES, M. D.

4 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3, 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 18, 1927, to March 30, 1927.

that I last saw her alive on April 2, 1927

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis 5 Yrs.
Chronic Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilitation of Heart 1 ds.
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw. Kendall M. D.

4/1, 1927 (Address) 24 N. Fulton Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| New Cathedral | April 5 1927 |

20 UNDERTAKER George J. Smith ADDRESS 532 Collins

Spec.—1-12-23—M&T—500 Blks.

E 20870 HEALTH DEPARTMENT—CITY OF BALTIMORE E 20870

CERTIFICATE OF DEATH. 27-48 117

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) West Baltimore Gen. Hosp. (St.) (WARD)

2-FULL NAME James M Dier

(a) RESIDENCE NO. 721 N. Mc Cabe Court WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) 12/22/21

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| 5 | 6 | 3 | 9 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Colored child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER L. J. Maier

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Bolivia Persons

13 BIRTHPLACE OF MOTHER (city or town) Del. (State or country)

14 Informant (Address) West Baltimore Gen. Hosp.

15 Filed APR 4 1927 19 E. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/31 1927

17 I HEREBY CERTIFY, That I attended deceased from 3/16, 1927, to 3/31, 1927, that I last saw the alive on 3/15 1927 and that death occurred, on the date stated above, at 5 00 P m.

The CAUSE OF DEATH* was as follows: Acute appendicitis

(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) Jaundice & Stricture

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 3/16/27

Was there an autopsy? Yes What test confirmed diagnosis? Clinical & Operative

(Signed) Dr. Wm. F. Kopp M. D.

Address West Baltimore Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL 4/6 1927

20 UNDERTAKER J. J. Moran

ADDRESS 3000 E Baltimore

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20871

## CERTIFICATE OF DEATH

90 E 20871

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 326 N. Robinson St. 6-11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry F. Graff

(a) RESIDENCE NO. 326 N. Robinson St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | S. |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hannah Graff

6 DATE OF BIRTH (month, day, and year) Dec 4 1841

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 85 | 4 | 27 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wharfinger

(b) General nature of Industry, business, or establishment in which employed (or employer) Retired 086

(c) Name of employer Employee

9 BIRTHPLACE (city or town) Ohio

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town) Ohio

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Ohio

(State or country)

14 Informant Hannah Graff

(Address) 326 N. Robinson

15 Filed APR - 4 1927 19 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1927, to Apr. 1, 1927

that I last saw him alive on Mar. 31, 1927,

and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Chr. Endocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Auscultation tests

(Signed) J M Dellett, M. D.

Apr 3 1927 (Address) 62 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem

Date of Burial 4/4 1927

20 UNDERTAKER J. A. Moran

ADDRESS 326 E Baltimore

very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

E 20872

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

129 E 20872

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 209 S. Regester St., 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick A Kues.

(a) RESIDENCE NO. 209 S. Regester St. 2 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 1 mos. 14 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary J. Kues.

6 DATE OF BIRTH (month, day, and year) Feb. 18th 1853

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 74 | 1 | 14 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER Henry Kues.

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Fredricka Brocker

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany.

14 Informant Mary J. Kues. (Wife)

(Address) 209 S. Regester St.

15 Filed ..... 19.. ..... Registrar

APR 4 1927 C. HEMPSTONE JONES, M.D.

Per R R

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1st 1927

17 I HEREBY CERTIFY, That I attended deceased from March 27 19.. to April 1 19 27

that I last saw h.. alive on April 1 19 27

and that death occurred, on the date stated above, at 7 15 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral artero sclerosis

Chronic nephritis

Chronic myocarditis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Bruce Douglas, M. D.

4/1, 1927 (Address) for E. Bates Sr

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

Date of Burial April 4 1927

20 UNDERTAKER Kelly & Jailer

ADDRESS 4038 Wash Ave

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20873

100-001

## CERTIFICATE OF DEATH.

E 20873

1-PLACE OF DEATH Baltimore City Hospitals — REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of HALTIMORE: (No. [illegible] Ward) 26-2

2-FULL NAME Edward Beck

(a) RESIDENCE NO. 3414 Lexington Ave Ward

(Usual place of abode) Lexington Ave (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of): Rose Beck

6 DATE OF BIRTH (month, day, and year): april 12 1877

7 AGE — Years: 49 — Months: 11 — Days: 20 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Va.

(State or country)

PARENTS

10 NAME OF FATHER Fredrick Beck

11 BIRTHPLACE OF FATHER (city or town): Germany

(State or country)

12 MAIDEN NAME OF MOTHER Mary Foulcer

13 BIRTHPLACE OF MOTHER (city or town): Va.

(State or country)

14 Informant Baltimore City Hospitals

(Address)

Filed ..... 19..... C. HAMPSON JONES, M. D.

R-4 132 Per ..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 April 2,

17 I HEREBY CERTIFY, That I attended deceased from Aug. 25, 1926 to April 2 1927

that I last saw h[illegible] alive on April 2 1927

and that death occurred, on the date stated above, at 4.05 p. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia (terminal

Hemorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Alcoholism & Depression

(Duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical findings

(Signed) Harry Goldsmith M.D.

4/2/27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel Cemetery — Date of Burial: april 6 1927

20 UNDERTAKER: Zirkin & Zirkin — ADDRESS: 1739 E. Eager St.

Key important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20874

## CERTIFICATE OF DEATH.

3 E 20874

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1564 N. Caren 15-71 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John E. Gleason

(a) RESIDENCE. No. 1564 N Caren ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 7th 1871

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 35 | 9 | 25 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Iron foundry

(c) Name of employer: B & O R.R.

9 BIRTHPLACE (city or town) (State or country): Baltimore City

PARENTS

10 NAME OF FATHER: Roger Gleason

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Winifred Buttle

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Annie Gleason 1564 N. Caren St

15 Filed APR 4 1927. C. HAMPSON JONES, M. D. Registrar Per R H

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2nd 1927

17 I HEREBY CERTIFY, That I attended deceased from March 29th, 1927, to April 2nd, 1927, that I last saw him alive on April 2nd, 1927, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) — yrs. — mos. 5 d.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm. T. Smith M.D.

4/3. 1927 (Address) 1701 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters

DATE OF BURIAL: 4/5 1927

20 UNDERTAKER: John J. Fields ADDRESS 1200 W. Lombard

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20875

## CERTIFICATE OF DEATH.

49 E 20875

1-PLACE OF DEATH Baltimore City Hospitals. REGISTERED NO.

City of BALTIMORE: (No. Baltimore, Md. St. 20-49 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nathan Lehman,

(a) RESIDENCE NO. 2103 W. Saratoga St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX male, 4 Color or Race white, 5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Lehman

6 DATE OF BIRTH (month, day, and year) Age 54. Unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 54 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teamster. 62

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.

(State or country)

PARENTS

10 NAME OF FATHER Anse Lehman

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Interment (Address) Mt. Lehman, 1102 Saratoga St

FILED APR 4 1927 C. HAMPSON JONES, M. D.

Per Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3, 1927. 19

17 I HEREBY CERTIFY, That I attended deceased from 2-2-26 19 , to 3-3-27 , 19 ,

that I last saw h.. alive on 3-3-27 , 19 ,

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the bladder.

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted at home.

If not at place of death!

Did an operation precede death! No. Date of

Was there an autopsy! No.

What test confirmed diagnosis!

(Signed) N. B. Cyco & Co. M. D.

, 19 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Hebrew Cemetery Date of Burial April 5 27

20 UNDERTAKER J. Ahearn & Co ADDRESS 2316 Eutaw Pl

Key Important. See Instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

# E 20876 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 20876

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 318-28 St. 12-50 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas P. Clark Jr

(a) RESIDENCE NO. 318 W. 28th St., 12 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| M. | C. | — |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2/26/26

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 1 | 1 | 6 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Thos P Clark Jr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Jessie Hatchett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Jessie Clark
(Address) 318-28 St

15 Filed APR - 4 1927 C. HAMPSON JONES, M. D. Registrar

Per

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/2 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows: Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) John H. Lowman, M. D.
(Coroner.)

4/4 1927 (Address) 1132 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem. DATE OF BURIAL 4/5 1927

20 UNDERTAKER Sam Rhens ADDRESS 578 N Bond
Sam Rhensley

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20877

CERTIFICATE OF DEATH.

E 20877

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home & Infirmary St. Ward)

2-FULL NAME Mrs Maria Crane

(a) RESIDENCE NO. 309 Pennsylvania Ave; Towson St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced (or) WIFE of: Charles C Crane

6 DATE OF BIRTH (month, day, and year): Feb 21 -

7 AGE: Years 75 Months 1 Days 13 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Oklahoma

PARENTS

10 NAME OF FATHER: Geo W. Hauser

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Md

12 MAIDEN NAME OF MOTHER: Emeline McCoy

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Va

14 Informant: Daniel M Hauser

(Address) 309 Penna Ave Towson

4 1927 C. HAMPSON JONES, M. D. Registrar

Per AKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

April 4, 1927

17 I HEREBY CERTIFY, That I attended deceased from March 28 1927, to April 4, 1927, that I last saw her alive on April 4, 1927, and that death occurred, on the date stated above, at 6.15 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Arterial Sclerosis

Hypertension

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Vernon H. Norwood M. D.

April 4 1927 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — Date of Burial: 4/6/27

20 UNDERTAKER: Julian Cook — ADDRESS: 501 E North Ave

Very Important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 20878

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20878

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 740 Poplar grove st. (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Hiram P. Corliss.

(a) RESIDENCE NO. 740 Poplar grove st. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, (widowed) or divorced HUSBAND of or) WIFE of Lucretia Corliss

6 DATE OF BIRTH (month, day, and year) Oct-27-1843

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 83 | 5 | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None - retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Conn.

PARENTS

10 NAME OF FATHER Corliss.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Conn.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Conn

14 Informant Walter L Mackey

(Address) 740 Poplar Grove

15 Filed 4-4 1927, 19 HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/4 1927

17 I HEREBY CERTIFY, That I attended deceased from 3/31, 1927, to 4/4, 1927.

that I last saw h alive on 4/4, 1927.

and that death occurred, on the date stated above, at 12 07 m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis.

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Terminal Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? In home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Laboratory

(Signed) Edward [illegible], M. D.

4/4, 1927 (Address) 1041 Baltimore Ave. Hopkins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL U. S National

DATE OF BURIAL 4/6 1927

20 UNDERTAKER William Cook

ADDRESS 502 E Monument

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20879

## CERTIFICATE OF DEATH.

112 E 20879

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 532 E. North Ave St. 9-18 (Ward)

2-FULL NAME Ella Crane

(a) RESIDENCE NO. 532 E. North Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | white | single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) ????

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 65 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Ireland

PARENTS

10 NAME OF FATHER John Crane

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Anna Devereaux (niece)

(Address) 532 E. North Ave

15 Filed 19

C. HAMPSON JONES M. D.

Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Gastritis

(duration) yrs. mos. ds.

(Signed) J. H. Ellis M. D.

(Coroner)

4/4/27 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — Date of Burial 4/5 19 27

20 UNDERTAKER William Cook — ADDRESS 502 E. North

Per

Very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20880

E 20880

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Balto City Hospitals

City of BALTIMORE: (No. Balto Md St., 7-12 Ward)

REGISTERED NO. 100-01

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Battista

(a) RESIDENCE NO. 2510 Eager Place Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced (or) WIFE of James Battista

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 49 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Italy

PARENTS

10 NAME OF FATHER Giannaro Del Giudice

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Italy

12 MAIDEN NAME OF MOTHER Elizabeth Valentine

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Italy

14 Informant Balto City Hospts

(Address) Balto Md

15 Filed....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-4 1927

17

I HEREBY CERTIFY, That I attended deceased from 3-24- 1927 to 4-4 1927

that I last saw h alive on 4-2 1927

and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH was as follows:

Terminal Bronchopneumonia

Emphysema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxic Involutional Psy Chosis, Presenile Type

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical findings

(Signed) Harry Fegaroff M. D.

(Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Date of Burial 4/6 1927

20 UNDERTAKER William Cook ADDRESS 502 E North Ave

very important. See instructions on back of certificates.

E. HAMPSON JONES, M. D.

Registrar

Cor.—12-9-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20881

## CERTIFICATE OF DEATH.

E 20881

24-33 + 197

1-PLACE OF DEATH

REGISTERED NO._____

City of BALTIMORE: (No. South Baltimore General Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rojelio Perez alias Manuel Williams.

(a) RESIDENCE NO. Do not know. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male. | White. | Single. |

3a If married, widowed, or divorced HUSBAND of (or) WIFE of ---- ----

6 DATE OF BIRTH (month, day, and year) Do not know.

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 25 | ---------- | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Oiler.

(b) General nature of industry, business, or establishment in which employed (or employer) S/S Munorleans.

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) Porto Rico.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Do not know.

14 Informant Police Report. S.D.

(Address)

15 Filed 1927 C. HAMPSON JONES M. D. Registrar

1927 Per ARH

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy and inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal hemorrhage due to a pistol shot wound of the abdoren.
Homicide.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

(duration) .....yrs. .....mos. .....ds.

(Signed) Otto M. Bernhardt M. D. (Coroner)

3/28 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death..... yrs.,..... mos.,..... ds. In the State..... yrs.,..... mos.,..... ds.

Where was disease contracted, if not at place of death?

S/S Munorleans, Pier 5 Locust Point

Former or usual residence March 10, 1927.

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYL[illegible] Date of Burial APR 4 1927 19

20 UNDERTAKER [illegible] ADDRESS Commissioner Health.

THE MORGUE

Very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20882

# CERTIFICATE OF DEATH.

E 20882

1-PLACE OF DEATH

City of BALTIMORE: (No. Carroll Dump 21-72 St. Ward) 181-083

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Unknown

(a) RESIDENCE NO. Unknown St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | Col'd | Unknown |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| About | 25 | - | — | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Unknown
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant S. W. Police Sta
(Address) Balto

15 Filed ....., 19.....

1228 Reg. No. 4 [illegible]

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16th 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Overcome by Gas fumes
Laid down & went to sleep
on Carroll Dump

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Thos. B. Horton M. D.
(Coroner)

March 30-1927 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 19

20 UNDERTAKER ADDRESS

very important. See instructions on back of certificate.

C. HAMPSON JONES, M.D.
Commissioner of Health.

UNIVERSITY OF MARYLAND
APR 4 1927

Pay to MORGUE

RKH Registrar

Cor.—12-9-25—A Co.—200 Bks.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20883

## CERTIFICATE OF DEATH.

181-00

E 20883

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Carroll Dump St. 21-72 Ward)

2-FULL NAME Unknown

(a) RESIDENCE NO. Unknown St._____ Ward_____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | Unknown |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year)
Unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| About | 30 | — | — | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Unknown
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant S. W. Police Sta
(Address) Balto. Md

15 Filed_____, 19_____
Per_____ Registrar

1225 THE MORGUE

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest and jury of inquiry.) thereon and from the evidence obtained by (Inquest, autopsy or inquiry.) .....find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Overcome by Gas fumes - Laid down & went to Sleep on Carroll Dump

(duration) hrs.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Thos. B. Horton M. D.
(Coroner)

March 30 1927 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See instructions for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

UNIVERSITY OF MARYLAND
C. HAMPSON JONES, M. D.
Commissioner of Health
APR 5 - 1927

very Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 20884

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20884

## CERTIFICATE OF DEATH.

161-21

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1620 Hrelwood Ave ST. 15-21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Smith-

(a) RESIDENCE NO. 1628 Hrelwood Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Colored | Single |

5a If married, widowed, or divorced HUSBAND of or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) March 31, 1927

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or 5 min. |
|---|---|---|---|---|
| | | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Oscar Smith-

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Georgie Bell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Georgie Smith (Address) 1628 Hrelwood Ave

15 Filed , 19 Registrar

1226

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31, 1927

17

I HEREBY CERTIFY, That I attended deceased from 3/31- , 19 27 , to 3/31 , 19 27 .

that I last saw her alive on 3/31/27 , 1927 ,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Convulsions birth

4 Months Gestation

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Probably Lobar

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? NO Date of

Was there an autopsy? NO Clinical

What test confirmed diagnosis?

(Signed) A. Lee Ellis M. D.

4/1, 1927 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL APR 4 - 1927 19

20 UNDERTAKER Commissioner Health.

ADDRESS

UNIVERSITY OF MARYLAND
C. HAMPSON JONES, M. D.

Please write very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20885

11-081

E 20383

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 3213 E Elliott St., 16-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Gonuck

(a) RESIDENCE NO. 3213 E Elliott St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S. if of foreign birth 13 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1889 - Jan

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 38 | 3 10 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Poland
(State or country)

PARENTS

10 NAME OF FATHER Paul Gonuck

11 BIRTHPLACE OF FATHER (City or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Arbuska

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14 Informant Leokadya Gonuck
(Address) 3213 Elliott St

15 Filed C. HAMPSON JONES, M. D. Registrar
1927 Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3 1927

17 I HEREBY CERTIFY, That I attended deceased from April -1- 1927 to April -3- 1927

that I last saw h. alive on Feb 2 - 1927

and that death occurred, on the date stated above, at 6 12 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) La Grippe

(duration) yrs. mos. 10 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. J. Davidson, M. D.

. 19 (Address) 3035 Adonnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| St Stanislaus Cem | April 5 1927 |
| 20 UNDERTAKER | ADDRESS |
| Stefan Galkowski | Spring |

very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

E 20886

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20886

## CERTIFICATE OF DEATH

101-091

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 31 Park Ave. Raspburg St. 26-42 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Gertrude Forestell

(a) RESIDENCE NO. 31 Park Ave. Raspburg St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. 2 mos. 14 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leo Walter Forestell

6 DATE OF BIRTH (month, day, and year) Jan 19th 1900

| 7 AGE | Years | Months | Days | IF LESS than 1 day ... hrs. or ... min. |
|---|---|---|---|---|
| | 27 | 2 | 13 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Keeper

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER Charles F. Eckert

11 BIRTHPLACE OF FATHER (City or town) Balto. Md

(State or country)

12 MAIDEN NAME OF MOTHER Josephine A. Samolinski

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto. Md.

14 Informant Leo Walter Forestell

(Address) 31 Park Ave Raspburg.

15 Filed APR 4 1927 18 C. HAMPSON JONES, M.D. Registrar

By NKH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2nd 1927

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1927, to Apr 2, 1927, that I last saw h[illegible] alive on April 1, 1927, and that death occurred, on the date stated above, at 7.30 a. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) acute dilatation of heart

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?* Physical signs

(Signed) [illegible], M. D.

19 4/4/27 (Address) Mapleton. Belair Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — Date of Burial April 5th 1927

20 UNDERTAKER Lilly & Geiser — ADDRESS 403 S Wolfe St

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 20887

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20887

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE. (No.) 2440 (St.) Asquith (Ward) 9-46

REGISTERED NO. 1615

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irvin George Foerdens

(a) RESIDENCE No. 2440 (St.) Asquith (Ward)
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 30 1927

7 AGE: Years | Months | Days: 4 | If LESS than 1 day, hrs. or min.: 5

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country) Maryland. Baltimore

PARENTS

10 NAME OF FATHER Charles H. Foerdens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Golda Brefer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant: Mrs Golda Foerdens
(Address) 2440 asquith St

15 Filed 4 1927 C. HAMPSON JONES, M. D. Registrar
Per RKH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 3/27 19

17 I HEREBY CERTIFY, That I attended deceased from March 24 1927 to Apr 3 1927.
that I last saw him alive on Apr 2 1927.
and that death occurred, on the date stated above, at 6 8 m.

The CAUSE OF DEATH* was as follows:

Premature - about 6½ mos child

CONTRIBUTORY (Secondary) Premature (about 6½ mos child) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? physical

(Signed) W. S. Niblett, M. D.
4/4/27 (Address) 2220 Garrison ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem — DATE OF BURIAL: Apr 5 1927

20 UNDERTAKER: Jos Foerdens Son — ADDRESS: 217 S. Paca

THIS IS very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 20888

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20888

## CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 415 Grindall St ST., 24-33 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Shugars

(a) RESIDENCE No. 415 Grindall ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William D Shugars

6 DATE OF BIRTH (month, day, and year): Jan 14 1862

7 AGE: Years 63. Months 2 Days 19

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Charles Long

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Anderson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant George L Shugars

(Address) 415 E Grindall St

15 Filed 4 1927 C. HAMPSON JONES, M. D.

Ref Register

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4. 3. 27 19

17

I HEREBY CERTIFY, That I attended deceased from March 14, 1927, to April 3, 1927,

that I last saw her alive on April 3, 1927

and that death occurred, on the date stated above, at 11.45 a m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Chronic nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical & laboratory findings

(Signed) J. Edward Torrie, M. D.

4. 3, 1927 (Address) 107 East Mosher

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross

DATE OF BURIAL: Apr. 6" 1927

20 UNDERTAKER: Joseph B Cook

ADDRESS: 1003 W Fayette St

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 20889

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 20889

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 7 Seven Mile Lane (ST.) 27-55 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah L. Fisher.

(a) RESIDENCE NO. 7 Seven Mile Lane ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. 9 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel F. Fisher

6 DATE OF BIRTH (month, day, and year) June 19, 1873

| 7 AGE Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|
| 53 | 9 | 14 15 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER William Hurst

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Louisa Kuster

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Daniel F. Fisher

(Address) 7 Seven Mile Lane

15 4 1927 C. HAMPSON JONES, M. D. Registrar

Per RAH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3. 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 20. 1927. to April 3. 1927.

that I last saw her alive on " 3. 1927.

and that death occurred, on the date stated above, at 7.30 A. m.

The CAUSE OF DEATH* was as follows:

Broncial Asthma

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Valvular heart Disease (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. McGeary, M. D.

4/3. 1927 (Address) 3901 Fairview Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Apr. 6 1927

20 UNDERTAKER Mr. & Mrs. John W. Teufel & Son — ADDRESS 50 W. Fayette St

THIS is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 20890

# HEALTH DEPARTMENT—CITY OF BALTIMORE

10-E 20890

## CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital 7-4 ST. ..... WARD)

2-FULL NAME Blanche Burford

(a) RESIDENCE NO. 115 S. Chapel ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. 9 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Colored | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 8, 1904

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min |
|---|---|---|---|---|
| | 22 | 9 | 26 28 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Burford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Lillie Auster

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records.
(Address)

15 Filed 4 1927 C. HAMPSON JONES, M. D. Registrar
Per .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4 1927

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1927, to April 4, 1927, that I last saw her alive on April 4, 1927, and that death occurred, on the date stated above, at 7 52 a. m.

The CAUSE OF DEATH* was as follows:

Tonsillar + Pharyngeal Diphtheria

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Bac. Culture

(Signed) Myron G. Tull, M. D.

4/4, 1927 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Actony Cem. DATE OF BURIAL Apr. 5 1927

20 UNDERTAKER Chas. H. Johnson & Son ADDRESS 7 Bolton

Spec.—12-9-25—A Co.—200 Bks.

E 20891

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20891

## CERTIFICATE OF DEATH.

48

1-PLACE OF DEATH

City of BALTIMORE: (No. 114 E Fort Ave 14-33 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susanle Baker

(a) RESIDENCE NO. 114 E Fort ave. 14 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced (or) WIFE of: Reuben Baker

6 DATE OF BIRTH (month, day, and year): 1846.7.21

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 80 | 8 | 11 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country): Frederick Co Md.

PARENTS

10 NAME OF FATHER: Jas Mullins

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Ireland

12 MAIDEN NAME OF MOTHER: Matilda Mahoney

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Ireland

14 Informant: Edward E Baker

(Address): 114 E Fort Ave

15 4 1827 C. HAMPSON JONES, M. D.

19

Per Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4.12 1927

17

I HEREBY CERTIFY, That I attended deceased from 4.1 1926, to 4.12 1927.

That I last saw h[illegible] alive on 4.12 1927.

and that death occurred, on the date stated above, at 9.15a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of face

(duration) 1 yr. mos. ds.

CONTRIBUTORY (Secondary): Impredicibles

(duration) yrs. mos. ds. Two months

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L Hurlington, M. D.

, 19 (Address) 102 E Fort ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park.

Date of Burial: 4/15 1927

20 UNDERTAKER: J. F. Tabor Sons

ADDRESS: 131 Light St.

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20892

## CERTIFICATE OF DEATH.

46 E 20892

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 530 N. Central ave ST. 58 WARD)

2-FULL NAME Lavinia Hamilton

(a) RESIDENCE No. 530 N. Central ave. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: John H Hamilton

6 DATE OF BIRTH (month, day, and year): Apr 12 1879

7 AGE

| Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|
| 48 | 11 | 10 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Eli F Dennis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Mary Townsend

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Raymond H Hamilton

(Address): 530 N. Central ave

15 Filed R-5 1927 Per C. HAMPTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-2- 1927

17 I HEREBY CERTIFY, That I attended deceased from 3-9- , 1927 , to 4-2- , 1927 , that I last saw h alive on 4-1- , 1927 , and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus.

unknown.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W H Cargier, M. D.

4-3- 1927 (Address) 611 N. Carolin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Antrim Cemetery

DATE OF BURIAL: 4-5 1927

20 UNDERTAKER: Mrd Chas E. Bailey

ADDRESS: 1424 Pennsylvania ave

Spec.—1-10-21—M&T—1500 Blks.

E 20893 HEALTH DEPARTMENT—CITY OF BALTIMORE E 20893

## CERTIFICATE OF DEATH.

REGISTERED NO. 19-52 49

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 900 N. 37 St ST., (WARD) 19

2-FULL NAME William Liest

(a) RESIDENCE NO. 900 N. 37 St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 1860

7 AGE: Years 67 Months 2 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto City

PARENTS

10 NAME OF FATHER: John Liest

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Barbara Knoor

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Belgium

14 Informant: Geo. H. Liest (Address) 900 N. 37 St

15 Filed 1927, 19 C. HAMPSON JONES, M.D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-30 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1926, to Apr. 30 1927, that I last saw h[e] alive on Apr 30 1927, and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder (Ca)

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Prostate

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Microscopic

(Signed) C. F. Lingel M. D.

4-5 1927 (Address) 3701 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dale Cemetery DATE OF BURIAL Apr 5 1927

20 UNDERTAKER: A S Marshall ADDRESS 3534 Falls Rd

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 20894

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20894

## CERTIFICATE OF DEATH.

101-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 537 Orchard ST. 17-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Brown

(a) RESIDENCE NO. 537 Orchard ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | Black | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Brown

6 DATE OF BIRTH (month, day, and year) Mar. 17/55

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or min. |
|---|---|---|---|---|
| | 72 | | 16 | 15 |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Anne Arundel Co. Md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) unknown

14 Informant Minnie Brown
(Address) 537 Orchard St

15 Filed APR 5 1927 C. HAMPSON JONES, M. D. Registrar
For RK

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apl 2 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar. 2, 1927, to Apl 2, 1927,

that I last saw ~~him~~ alive on Apl 1, 1927,

and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) H. D. Smith, M. D.

4/4, 1927 (Address) 129 W. Lee St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Mt Auburn Ct | Apl 5 1927 |
| 20 UNDERTAKER | ADDRESS |
| L. W. Brown & Son | 1011 W. Fayette |

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 20895 HEALTH DEPARTMENT—CITY OF BALTIMORE E 20895

## CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1132 W. Cross St. 4-1-29 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Lee Miller

(a) RESIDENCE NO. 1132 W. Cross ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | white | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) apr 4 1927

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 0 | 0 | 1 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Charles A. Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto - Md

12 MAIDEN NAME OF MOTHER Josie L. Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Charles A. Miller

(Address) 1132 W. Cross St

15 Filed APR - 5 1927 C. HAMPSON JONES, M. D. Registrar

Per R. K.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr 4 1927 to Apr 4 1927

that I last saw him alive on Apr 4 1927

and that death occurred, on the date stated above, at 10:50 p.m.

The CAUSE OF DEATH* was as follows:

Premature Birth

7 mo Gestation mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) John G. Schwarzenberg M. D.

, 19 (Address) 1176 W Lewis St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL W.V. Olivet — DATE OF BURIAL Apr 5 1927

20 UNDERTAKER Mrs. Mrs. J. W. Teufel & Son — ADDRESS 801 W. Fayette

TION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31

E 20896

E 20896

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. 1-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Orville Smoot

(a) RESIDENCE NO. 3139 Fait Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

very important. See instructions on back of certificates. Fatal accident: Date of occurrence; Hour of occurrence; Place of occurrence; Kind of accident; Nature of injury; Was injury at work? Nature of business; Was injury in or about mine? Was injury in or about factory? Was injury in or about railroad? Was injury in or about quarry? Was injury in or about building? Was injury in or about bridge? Was injury in or about boat? Was injury in or about wharf? Was injury in or about dock? Was injury in or about elevator? Was injury in or about warehouse? Was injury in or about machinery? Was injury in or about electricity? Was injury in or about steam? Was injury in or about explosives? Was injury in or about fire? Was injury in or about chemicals? Was injury in or about poisons? Was injury in or about drugs? Was injury in or about medicines? Was injury in or about surgical appliances? Was injury in or about X-ray? Was injury in or about radium? Was injury in or about electricity? Was injury in or about steam? Was injury in or about explosives? Was injury in or about fire? Was injury in or about chemicals? Was injury in or about poisons? Was injury in or about drugs? Was injury in or about medicines? Was injury in or about surgical appliances? Was injury in or about X-ray? Was injury in or about radium?

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 10-8-1881

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 45 | 5 | 24 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer (Engineer)

(b) General nature of Industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Louis M. Smoot

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore

12 MAIDEN NAME OF MOTHER Alice Sullens

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country)

14 Informant Hospital Records

(Address)

Filed APR - 5 1927, 19

C. HARRISON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-2 1927

17 I HEREBY CERTIFY, That I attended deceased from 3-21, 1927, to 4-2, 1927, that I last saw him alive on April 2, 1927, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Tuberculous ostealgy of left thigh with sinus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar pneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted?

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) W. C. Gatlett, M. D.

4/3, 1927 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel Cemetery — Date of Burial: Apr. 5 1927

20 UNDERTAKER: Henry Sander & Sons Inc — ADDRESS: 1710 Fleet St.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20897

## CERTIFICATE OF DEATH

E 20897

1-PLACE OF DEATH 217 W Monument St

CITY OF BALTIMORE: (No. Hotel Sherwood St. 11-23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances E. Lord

(a) RESIDENCE No. Hotel Sherwood ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married,~~ Widowed, or ~~Divorced,~~ (write the word): Widow

5a If ~~married,~~ widowed, or ~~divorced,~~ ~~HUSBAND OF~~ (or) WIFE OF: Late Charles R Lord

6 DATE OF BIRTH (month, day, and year): Dec 1st 1852

7 AGE: Years 75 | Months 3 | Days 4 | If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ohio

PARENTS

10 NAME OF FATHER: John Hatherhouse

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ohio

12 MAIDEN NAME OF MOTHER: Frances ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: C. F. Patterson

(Address)

15 Filed 5 1927, 19 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 3rd 1927

17

I HEREBY CERTIFY, That I attended deceased from March 14th, 1927, to April 3rd, 1927, that I last saw her alive on April 3rd 1927 and that death occurred, on the date stated above, at 8.45 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) 0 yrs. 0 mos 7 ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) Many yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Lucosyte Count

(Signed) Gordon Wilson, M. D.

4/4/1927 (Address) 715 Park Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Gillmount Cem

DATE OF BURIAL: April 5 1927

20 UNDERTAKER: Henry W Jenkins & Sons Co

ADDRESS: Orchard & Mc Culloh

Spec.—8-24-14—M. & T.—2000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20898 E 20898

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Gundry Sanaturom St. ) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosa Rumpelly

(Residence in Baltimore: No. Gundry Sanaturom St.: Life yrs., mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

| 3-SEX. | 4-COLOR OR RACE. | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) |
|---|---|---|
| Female | White | Widow |

6-DATE OF BIRTH, Dec. (Month) 29 (Day), 1857 (Year)

| 7-AGE, | If LESS than 1 day, |
|---|---|
| 69 yrs. 3 mos. 6 ds. | ....hrs. or....min.? |

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Lady
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Wm Rumpfeld

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Betzy Sundmund

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gundry Sanaturom

(Address) 4800 Frederick ave

15-

Filed APR 5 1927, 191.. C. HAMPSON JONES, M. D. Registrar.

Per RJ

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 4th (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 27 1914, to April 4 1927, that I saw h alive on April 4 1927, and that death occurred, on the date stated above, at 8.00 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 2 hrs. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) years yrs. mos. ds.

(Signed) Alfonso J. Carpenter M. D.

April 4, 1927. (Address) Carroll Mansion Hotel Columbia Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

| 19-PLACE OF BURIAL OR REMOVAL, | DATE OF BURIAL, |
|---|---|
| Bald Hebrew Cem | 4/6, 1927 |
| 20-UNDERTAKER | ADDRESS |
| Jack Lewis | 1439 E Balt st |

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20899

## CERTIFICATE OF DEATH.

11-001 V.

E 20899

1-PLACE OF DEATH

REGISTERED NO._____

City of BALTIMORE: (No. 1379 Filmore St. 15-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Dyson

(a) RESIDENCE NO. 1379 Filmore St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred / 0 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) Sept 22, 1904

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 22 | 5 6 | 10 9 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) St Mary's Co

(State or country) Md.

PARENTS

10 NAME OF FATHER Clarke Dyson

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) St Mary's Md.

12 MAIDEN NAME OF MOTHER Georgia Brooks

13 BIRTHPLACE OF MOTHER (city or town) St Mary's

(State or country) Md.

14 Informant Margaret Dyson

(Address) 1379 Filmore St

15 Filed APR-5 1927 C. HAMPSON JONES, M. D. Registrar

Per R.K.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1 19 27

17 I HEREBY CERTIFY, That I attended deceased from Mar 30, 19 27, to April 1, 19 27, that I last saw him alive on April 1, 19 27, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

1a Grippe

(duration) ____ yrs. ____ mos. 10 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ____ yrs. ____ mos. 5 ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) E. Wallman Frey, M. D.

April 2, 19 27 (Address) 1928 Pimlico Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion — Date of Burial April 5 19 27

20 UNDERTAKER Samuel H. Chase Sons — ADDRESS 1400 Monroe

very important. See instructions on back of certificate. Full statement of OCCUPATION is

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 20900 — 31 — E 20900

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 1621 Argyle Ave St. 4-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Arthur Stanford

(a) RESIDENCE NO. 1621 Argyle Av St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Stanford

6 DATE OF BIRTH (month, day, and year): July 1892

7 AGE — Years: 34 — Months: 9 — Days: 8 — IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cab Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer): 031

(c) Name of employer

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER: Chas Stanford

11 BIRTHPLACE OF FATHER (City or town): Md

(State or country)

12 MAIDEN NAME OF MOTHER: Ida Burse

13 BIRTHPLACE OF MOTHER (City or town): Md

(State or country)

14 Informant: Mrs Ida Stanford

(Address): 1621 Argyle Ave

15 Filed APR - 5 1927, 19 — C. HARRISON JONES, M. D. Registrar

Per R. M.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/4 1927

17 I HEREBY CERTIFY, That I attended deceased from April 17, 1926, to Apr 4, 1927

that I last saw him alive on Apr 2, 1927

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Evisceration (duration) yrs. 1 mos. ds.

18 Where was disease contracted ?

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum

(Signed) H. R. Slaughter, M. D.

4/4. 1927 (Address) 825 N. Fremont Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — Date of Burial: April 7th 1927

20 UNDERTAKER: Clarence E. Shyfel — ADDRESS: Balto Md

very important. See instructions on back of certificates.

Stock—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

B 20901

## CERTIFICATE OF DEATH.

E 20901

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1 PLACE OF DEATH

CITY OF BALTIMORE: (No.) 424 E 20th ST. (or) WARD) 12-19

2 FULL NAME Minnie Nordorft

(a) RESIDENCE NO. 424 E 20th ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? 42 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced (or) WIFE of August H Nordorft

6 DATE OF BIRTH (month, day, and year) April 4th 1871

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 56 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Philip Kinling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Marie Heimes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Ruth E Nordorft

(Address) 424 E 20th st

15 Filed APR-5 1927 C. HAMPSON JONES, M. D. Registrar per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4th 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug-6 1926 to April 4 1927.

that I last saw her alive on April 3 1927.

and that death occurred, on the date stated above, at 4.42a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Gall Bladder.

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Metastasis in Lungs

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Nov 4-1926

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E Gill Hall, M. D.

Apr-4 1927 (Address) 1631 E North av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL April 7th 1927

20 UNDERTAKER George Schilling & Sons

ADDRESS 112 E Monument

IMPORTANT is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20902

## CERTIFICATE OF DEATH.

E 20902

117

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 15-23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Brown

(a) RESIDENCE NO. 1342 Woodyear St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | col | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Brown

6 DATE OF BIRTH (month, day, and year) 1876

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 51 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER James Johnson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Fannoe Harden

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Frank Brown

(Address) 1342 Woodyear St

15 Filed ..... 19 .....

Per ..... Registrar

C. HAMPSON JONES, M. D.

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 2/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia-Empyema

(Autopsy at Hopkins)

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Peritonitis (secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) J. S. Rollins M. D.

(Coroner)

4/5/27 (Address) 505 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Mt Auburn Cem Date of Burial 4/5 1927

20 UNDERTAKER Samuel S. Lemley ADDRESS 57 Biddle

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20903

## CERTIFICATE OF DEATH.

129

E 20903

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2510 Woodbrook Ave 13-54 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Barton Edrington Sr.

(a) RESIDENCE NO. 2510 Woodbrook Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Edrington

6 DATE OF BIRTH (month, day, and year): Dec 1, 1852

7 AGE

| Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|
| 74 | 4 | 3 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: John Edrington

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant (Address): Mary Edrington 2510 Woodbrook Ave

Filed APR 5 1927 19 C. HAMPTON JONES, M. D. Registrar

By

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr. 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Mch 23 1927 to Apr 4 1927

that I last saw h alive on Apr 4 1927

and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) Wm T Malone M. D.

19 (Address) 1503 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery

DATE OF BURIAL: Apr 6 1927

20 UNDERTAKER: Joseph Sipe

ADDRESS: 1600 N Mott

(City)

THIS is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 20904

1-PLACE OF DEATH

City of BALTIMORE: (No. 1528 Abbottson St., 9-46 Ward)

REGISTERED NO. E 20904

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary Pack.

(a) RESIDENCE NO. 1528 Abbottson St. 7 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Benj Pack.

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 67; Months; Days; IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home work

(b) General nature of industry, business, or establishment in which employed (or employer): 37

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Memphis Tenn.

PARENTS

10 NAME OF FATHER Morgan

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Tennessee

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Tennessee

14 Informant: Frank Pate

(Address) 1528 Abbottson St

15 Filed ... 19 ... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4 1927

17 I HEREBY CERTIFY, That I attended deceased from April 3 1927, to April 4 1927, that I last saw h[illegible] alive on April 4 1927, and that death occurred, on the date stated above, at 2.42 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Brights disease

(duration) 4 yrs. ... mos. ... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr. O. F. Zimmerman, M. D.

4/4 1927 (Address) 1858 Harlond Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. Date of Burial: Apr 6 1927

20 UNDERTAKER: Joseph Dyer ADDRESS: 1608 W Noble Ave

very important. See instructions on back of certificates. EXACT STATEMENT OF OCCUPATION is

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20905

## CERTIFICATE OF DEATH.

REGISTERED NO. E 20905

1-PLACE OF DEATH Gouverneur Hosp. 31

CITY OF BALTIMORE: (No.) E. S. Hospital ST. 22-33 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilbur Freezer

(a) RESIDENCE NO. 38 E. Montgomery ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 8 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 20 1922

7 AGE 4 Years 8 Months 14 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Edward Freezer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Sykesville Md

12 MAIDEN NAME OF MOTHER Virgie Poole

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs. Virgie Freezer (Mother)

(Address) 38 E. Montgomery St

15 Filed APR - 5 1927 HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3 1927

17 I HEREBY CERTIFY, That I attended deceased from March 26, 1927, to April 3, 1927, that I last saw him alive on April 3, 1927, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Pulm. Tuberculosis

(duration) yrs. mos. 7 ds

CONTRIBUTORY (Secondary) Pulm. Hemorrhage

(duration) yrs. mos. 5 hrs.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. Wallace Weaver, M. D.

, 19 (Address) Franklin Square Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery — DATE OF BURIAL: April 6 1927

20 UNDERTAKER: John F. Denny — ADDRESS: 715 Light St

TION is very important. See instructions on back of certificates.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20906

## CERTIFICATE OF DEATH.

74.01 ✓

E 20906

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Edgewood Junction St. 47-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary S. Watkins.

(Residence in Baltimore: No. Conf'd Woman's Home Belvidere Ave. St.; 79 yrs., 7 mos. 16 ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

| 3-SEX. | 4-COLOR OR RACE. | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) |
|---|---|---|
| Fem | White | Widow |

6-DATE OF BIRTH, Sept 14, 1847
(Month) (Day) (Year)

7-AGE, 80
79 yrs. 6 mos. 20 ds.
If LESS than 1 day, ....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, James Nickerson

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Mary Chaney

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rachel Moore

(Address) 5209 Capeda Ave.

15-

Filed ....., 191..

C. HAMILTON JONES, M. Registrar.

APR - 5 1927 Per R.H.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 4, 1927
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 31 1927, to April 4 1927, that I saw h[er] alive on April 3 1927, and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ....yrs....mos....ds.

(Signed) Geo. C. Jackson M. D.

....., 191.. (Address) 1535 Gilmor St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

| 19-PLACE OF BURIAL OR REMOVAL, | DATE OF BURIAL, |
|---|---|
| London Park | April 7, 1927 |
| 20-UNDERTAKER | ADDRESS |
| P. Putnam & Son | 1723 W. Lafayette Ave |

Cor.—12-9-25—A Co.—200 Blks Samuel J. McGowns

Cor.—12-9-25—A Co.—200 Bks. Samuel J McGowns

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20907

# CERTIFICATE OF DEATH.

90 E 20907

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Nursery Road 4th St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Thomas McGowns

(a) RESIDENCE NO. 20 Myrtle Ave St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | Col | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lottie McGowns

6 DATE OF BIRTH (month, day, and year) 1900

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 27 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) N. Carolina

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country) N. C.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) N. C.

14 Informant Lottie McGowns

(Address) 720 Pendleton

15 Filed ..... 19 .....

Per ..... Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/2 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Malaria Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Samuel Thomas M. D.

(Coroner)

, 19 27 (Address) 3025 Pelham Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem Date of Burial April 5 1927

20 UNDERTAKER Dennis Carton ADDRESS 916 Eager

very important. See instructions on back of certificate. ... statement of OCCUPATION is

C. HAMPTON JONES, M.

APR 5 1927

Spec. 7-17-26—A Co.—200 Blks.

E 20908

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

31

E 20908

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 208 S. Dallas St. St., 3-5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Howard

(a) RESIDENCE NO. 208 S. Dallas St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Susie Howard

6 DATE OF BIRTH (month, day, and year): 1894

7 AGE: Years 33 — Months — Days — IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer on

(b) General nature of industry, business, or establishment in which employed (or employer): work on building

(c) Name of employer: not known.

9 BIRTHPLACE (city or town): Weston

(State or country): Md.

PARENTS

10 NAME OF FATHER: William Howard

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Maryland

12 MAIDEN NAME OF MOTHER: not known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Maryland

14 Informant: Arthur Gilliel

(Address): 205 S. Dallas St

15 Filed APR - 5 1927 19

C. HAMPSON JONES, M. D.

Registrar

Per R M

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 3 1927 19

17 I HEREBY CERTIFY, That I attended deceased from April 28 19 27 to April 3 1927

that I last saw him alive on April 3 19 27

and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary): not known

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? none

(Signed) R. L. Caslin M. D.

. 19 (Address) 1514 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: National

Date of Burial: April 5-1927

20 UNDERTAKER: Hamm Eastis

ADDRESS: Penn

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 20909 — REGISTERED NO. 3 3 E 20909

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL 12-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Tunstall

(a) RESIDENCE NO. 2212 Hunted St. St. City Ward

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Colored | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1892

| 7 AGE Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|
| 35 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Virginia

(State or country)

PARENTS

10 NAME OF FATHER Solomon Tunstall

11 BIRTHPLACE OF FATHER (city or town) Va

(State or country)

12 MAIDEN NAME OF MOTHER Emma Smith

13 BIRTHPLACE OF MOTHER (city or town) Va

(State or country)

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Registrar

APR 5 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar - 1 1927 to Apr. 3 1927, that I last saw her alive on April 3 1927, and that death occurred, on the date stated above, at 2.40 p m.

The CAUSE OF DEATH* was as follows:

Tuberculous Peritonitis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia Meningitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted, if not at place of death? Unknown - Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. Coulter Andrus, M. D.

. 19 (Address) Johns Hopkins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem Cepart Date of Burial 5 19 27

20 UNDERTAKER Daniel Easton ADDRESS 716

very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20910

## CERTIFICATE OF DEATH.

90 11

REGISTERED NO. E 20910

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Josephs Hospital

CITY OF BALTIMORE: (No. Caroline & Oliver ST., 14-20 WARD)

2-FULL NAME Lillian Nickens

(a) RESIDENCE NO. 1507. McCullough ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female. | Negro | Widowed — |

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 22, 1893

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| 33 | 32 | 3 | 11 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Jacksonville, Florida

PARENTS

10 NAME OF FATHER Wash Mason

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't know

12 MAIDEN NAME OF MOTHER Dora Mason

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't know

14 Informant Lewis Nickens

(Address) 1507 Mt. Cullough St.

15 Filed APR - 5 1927 C. HAMPTON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3 1927

17

I HEREBY CERTIFY, That I attended deceased from March 16, 1927, to April 3, 1927, that I last saw her alive on April 3, 1927, and that death occurred, on the date stated above, at 12:05 p. m.

The CAUSE OF DEATH* was as follows:

Aortitis.

Myocarditis.

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac. Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical.

(Signed) Clement K. Noonan, M. D.

, 19 (Address) St Josephs Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Woodlawn Cem | April 5 1927 |

20 UNDERTAKER Newell Easton ADDRESS 97 Encore

Spec.—1310-21—M&T—1500 Bks.

E 20911

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20911

## CERTIFICATE OF DEATH.

101-006

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1816 (St.) (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lula Baskerville Jackson

(a) RESIDENCE NO. 9 N. Poplar ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: John Jackson

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: 41 (Years / Months / Days; If LESS than 1 day, hrs. or min.)

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: John Jackson

(Address): 9 N Poplar

15 Filed 19 C. H. THOMPSON, M. D. Registrar

Per

R. 5 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 3 1927

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1927, to April 3, 1927.

That I last saw her alive on April 3, 1927,

and that death occurred, on the date stated above, at 11:30 P m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. Coleman M. D.

April 5 19 27 (Address) 1039 N Carrollton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: April 5 1927

20 UNDERTAKER: Daniel Easton

ADDRESS 916 Eager

TION is very important See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 20912

E 20912

1-PLACE OF DEATH

REGISTERED NO. 90

City of BALTIMORE: (No. 1919 Clifton Ave ~~St.~~ 15-21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Julia Virginia Gales

(a) RESIDENCE NO. 1919 Clifton Ave ~~St.~~ Ward

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. ✓ mos. ✓ ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? ✓ yrs. ✓ mos. ✓ ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maiden

6 DATE OF BIRTH (month, day, and year) Febry 4- 1848

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min.. |
|---|---|---|---|---|
| | 79 | 2 | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Nurse

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer None

9 BIRTHPLACE (city or town) Washington D.C.

(State or country)

PARENTS

10 NAME OF FATHER George Gales

11 BIRTHPLACE OF FATHER (City or town) Maryland.

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown

(State or country)

14 Informant Catherine G. Abell

(Address) 1919 Clifton Ave

15 Filed ~~Catherine G. Abell~~ M. D.

~~1919 Clifton Ave~~

5 1927 Per Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Jany 9 1927, to Apr 4 1927.

that I last saw her alive on Apr 3 1927.

and that death occurred, on the date stated above, at 1.20 a m.

The CAUSE OF DEATH* was as follows:

Hemorrhage (Cerebral)

(duration) ✓ yrs. ✓ mos. 2 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) ✓ yrs. 3 mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of None

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Methods

(Signed) George C. Shannon, M. D.

4/4, 1927 (Address) 700 Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means, and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION, OR REMOVAL | Date of Burial |
|---|---|
| London Park Cemetery | Apr 7 1927 |
| 20 UNDERTAKER | ADDRESS |
| Wm J. Rickert Sons | North Ave |

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20913 E 20913

## CERTIFICATE OF DEATH.

REGISTERED NO. 20-2890

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1911 W. Lombard ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John A Owens

(a) RESIDENCE NO. 1911 W Lombard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | White | Widowed. |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary L. Owens

6 DATE OF BIRTH (month, day, and year) 1859

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs or ..... min. |
|---|---|---|---|---|
| | 67 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) St. Marys Co Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant Joseph A. Norris

(Address) 1911 W. Lombard St.

15 Filed APR 5 1927, 19 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/4 1927

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1927, to April 4, 1927.

That I last saw him alive on April 3, 1927.

and that death occurred, on the date stated above, at 3 1 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage Myocarditis Hypertension

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood pressure & Physical

(Signed) Chas A Curtin, M. D.

4/4 1927 (Address) 2105 N Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. John's Cem St Marys Co. Md Ext.

DATE OF BURIAL Apr. 6 1927

20 UNDERTAKER Chas. W. Dill.

ADDRESS 3109 Greek Ave

TION is very important. See instructions on back of certificates.

Spec.—1-10 21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20914 E 20914

## CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Howard A Kelly Hospital ST. ..... WARD)

2-FULL NAME Mrs Mary A. Collier

(a) RESIDENCE NO. 616 Gordon Drive ST., WARD Albany, Ala.
(Usual place of abode)
Length of residence in city or town where death occurred non-resident yrs. mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. J. R. Collier

6 DATE OF BIRTH (month, day, and year) Oct 29 1868

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 58 | ✓ | 7 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Co.
(State or country) Alabama

PARENTS
10 NAME OF FATHER Dr D. L. Rountree
11 BIRTHPLACE OF FATHER (city or town) Murray Co
(State or country) Tenn
12 MAIDEN NAME OF MOTHER Georgia Thompson
13 BIRTHPLACE OF MOTHER (city or town) Baltimore Co
(State or country) Alabama

14 Informant Joshua R. Collier
(Address) Albany Alabama

15 Filed 5 1927 C. H. THOMPSON JONES, M. D.
Per ..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5, 1927

17 I HEREBY CERTIFY, That I attended deceased from April 5 1927 to Apr. 5 1927.
that I last saw her alive on Apr. 5 1927.
and that death occurred, on the date stated above, at 2 50 p. m.
The CAUSE OF DEATH* was as follows:
Cancer of rt. breast with metastasis to lungs
(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) None
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Albany, Ala.
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Exam. of tissue at the time
(Signed) Robert L. Fricke, M. D.
, 19 (Address) 1418 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Albany Alabama — DATE OF BURIAL April 6 1927

20 UNDERTAKER Chas. G. Black — ADDRESS 74 Walnut Ave.

TION is very important See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20915 — CERTIFICATE OF DEATH. — E 20915

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1000 Monroe Ave (St.) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie Young

(a) Residence No. 1000 Monroe St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Fe

4-COLOR OR RACE, Col

5-~~Single~~, ~~Married~~, Widowed or Divorced, (Write the word.) Widd

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Thomas Young

6-DATE OF BIRTH (month, day and year) 1859

7-AGE 68 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) General house-work
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12-MAIDEN NAME OF MOTHER, Nellie Walker

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Virginia

14- (Informant) Rampie Brazier
(Address) 1000 Monroe Ave

15- Filed 5 1927 C. HAMPSON JONES, M. D. Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr. 2 1927

17- I HEREBY CERTIFY, That I attended deceased from Jan. 1 1927 to Apr. 2 1927
that I last saw h alive on Apr 2 1927
and that death occurred, on the date stated above, at 11.30 P m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease
Duration yrs. mos. ds.
CONTRIBUTORY (Secondary) Rheumatism
(Duration) yrs. 3 mos. 15 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Ex.

(Signed) P. Garland Symmes M. D.
Apr 5 1927 (Address) 1334 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19-PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Laurel Cem. | Apr. 6, 1927 |
| 20-UNDERTAKER. | ADDRESS |
| Mrs J. L. Locks | 1302 Jefferson |

INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.—12-9-25—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20916

## CERTIFICATE OF DEATH.

146 E 20916

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospital 16-23 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Shaw

(a) RESIDENCE NO. 1321 W Lanvale St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Marcellus Shaw

6 DATE OF BIRTH (month, day, and year): 1892

7 AGE: Years 35 | Months | Days | If LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): N. C.

(State or country): Valley

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town): N. C.

(State or country)

12 MAIDEN NAME OF MOTHER: Mary Dockes

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): N. C.

14 Informant: Marcellus Shaw

(Address): 1321 W Lanvale St

15 Filed ... 19 ... C. HAMILTON JAMES, M. D. Registrar

For ... Acct

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

April 4, 1927

17 I HEREBY CERTIFY, That I attended deceased from March 30 1927 to April 4 1927

that I last saw her alive on April 4 1927

and that death occurred, on the date stated above, at 7 30 a m.

The CAUSE OF DEATH* was as follows:

Puerperal Convulsions and Septicemia

(duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms & Laboratory

(Signed) W B Dixon M. D.

19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Burgan N C Date of Burial April 19 27

20 UNDERTAKER: Samuel H Busby ADDRESS 7 E Baltimore

Be sure that every item is answered, as much as may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20917

## CERTIFICATE OF DEATH

E 20917

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. Union Memorial Hosp. St. 12-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Murray Clayton Bauer

(a) RESIDENCE NO. Havre de Grace, Md. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 4 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | white | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 7/16/26

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..hrs. or ..min.. |
|---|---|---|---|---|
| | | 8 | 20 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER Arthur Clayton Bauer

11 BIRTHPLACE OF FATHER (City or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Alice Murray

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant J. Clayton Bauer

(Address) Havre de Grace Md.

15 Filed APR 5 1927 C. HAMPSON JONES, M. D. Registrar

Per A.P.B.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/5 1927

17 I HEREBY CERTIFY, That I attended deceased from 4/1 1927, to 4/5 1927,

that I last saw him alive on 4/5 1927,

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Chronic Meningetis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Back injury (?)

(duration) yrs. 8 mos. 20 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Yes

(Signed) Joseph P. Sparks M. D.

, 19 (Address) U. M. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Havre de Grace Md. Date of Burial Angel Hill Cem Apr. 7 1927

UNDERTAKER Madison Mitchell ADDRESS Havre de Grace Md

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 20918

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

Not E 20918

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Edmund Sanders ST.) 27-48 (WARD)

2-FULL NAME Betty Maxwell

(a) RESIDENCE. No. Edmund Sanders ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 1 mos. 20 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| F. | W | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George D. Maxwell

6 DATE OF BIRTH (month, day, and year) Feb. 14, 1861

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 66 | 1 | 20 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER William G. Webb

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Amanda C. Woods

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant H. W. Webb
(Address) Calvert & 31st Sts.

15 Filed APR - 6 1927 19 L. HAMPSON JONES, M. D. Registrar
Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1926 to Apr 4 1927
that I last saw her alive on April 4 1927
and that death occurred, on the date stated above, at 5 P m.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
3d attack

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W. R. Pearce M. D.

4/4 1927 (Address) 2105 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Dublin, Md. | 4/6 1927 |

20 UNDERTAKER Henry W. Mears & Son ADDRESS 805 N. Calvert

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20919

## CERTIFICATE OF DEATH.

188-003

E 20919

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 14-20 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Regina Gallagher

(a) RESIDENCE NO. 1903 Linden Avenue St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? --yrs. -- mos. -- ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -------

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 64 | -- | -- | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Michael Gallagher

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Monaghan

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Walter A. McGlannan

(Address) 8 Montrose Ave., Catons.

Filed APR. 6 1927 HAMPSON JONES, M. D. Registrar

Per RM

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5 — 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Dislocation. Patella
Multiple bruises over body
15 days (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism
Deaden (duration) ..... yrs. ..... mos. ..... ds.

Sept 5 — 1927 (Signed) E. J. Kelly M. D.
(Coroner)
(Address) 1639 Bruadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Cathedral Cemetery | 4/5 1927 |

| 20 UNDERTAKER | ADDRESS |
|---|---|
| Henry Means & Son | 807 N Calvert St |

If DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20920 90 E 20920

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mercy Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 14-20 ST., WARD)

2-FULL NAME Augusta Gallagher

(a) RESIDENCE NO. 1903 Linden Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F. | W. | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs. or ....min. |
|---|---|---|---|---|
| 65 | | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Michael Gallagher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Monaghan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Walter A. McGlannan

(Address) 6 Montrose Ave. Catonsville

15 Filed APR 6 1927 19 Per H. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/5 1927

17

I HEREBY CERTIFY, That I attended deceased from 3/22, 1927, to 4/5, 1927

that I last saw her alive on 4/5, 1927

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Asthma & Chronic Bronchitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 4/6 1927

20 UNDERTAKER W. Bloomer & Son

ADDRESS 805 N. Calvert St.

TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20921

## CERTIFICATE OF DEATH.

31 E 20921

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals No. 2 St. Ward)

2-FULL NAME Raymond Metzger

(a) RESIDENCE NO. 3404 Gough st. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1897

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 30 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER August Metzger

11 BIRTHPLACE OF FATHER (city or town) Balto.

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Christine Waninger

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Hospital Records

(Address)

Filed APR 6 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3, 1927 19

17

I HEREBY CERTIFY, That I attended deceased from March 17, 19 27, to April 3, 19 27,

that I last saw him alive on April 3, 19 27,

and that death occurred, on the date stated above, at 7.15 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

CONTRIBUTORY Tuberculous enteritis

(Secondary) Tuberculous pleurisy with effusion

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

4-4-27 W. E. Gatchell, M. D.

(Signed) (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem. Date of Burial 4/7 1927

20 UNDERTAKER Both. J. Lemmon ADDRESS 1442 N Broadway

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20922

## CERTIFICATE OF DEATH.

E 20922

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Ind. Gen. Hosp

CITY OF BALTIMORE: (No. 11-24 ST. WARD)

2-FULL NAME Baby Harrison

(a) RESIDENCE No. Finksburg Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | White | Baby |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3-31-27

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or 5 min. |
|---|---|---|---|---|
| | | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Ind. Gen. Hosp

PARENTS

10 NAME OF FATHER Wm E. Harrison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Hungerford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard County

14 Informant Mrs Josephine Harrison

(Address) Finksburg Md

15 Filed ..., 19... C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-31-1927

17 I HEREBY CERTIFY, That I attended deceased from 3-31-27, 19..., to 3-31, 1927.

that I last saw him alive on 3-31, 1927.

and that death occurred, on the date stated above, at 3 20 P m.

The CAUSE OF DEATH* was as follows:

Premature separation of placenta with premature labor, Fetus 5 mo) (duration) ... yrs. mos ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno A Harrison Smith M. D.

, 19... (Address) Ind Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL 19 |
|---|---|
| W.M. | |
| 20 UNDERTAKER | ADDRESS |

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 20923

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20923

## CERTIFICATE OF DEATH

1-PLACE OF DEATH Maryland General Hospital

CITY OF BALTIMORE: (No. 13-54 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Bessie Stites

(a) RESIDENCE NO. 729 Newington Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 4/18/1873

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 53 | 11 | 17 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER James Stites

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Francis Burdt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Hospital Records.

(Address)

15 Filed APR 6 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/4 1927

17

I HEREBY CERTIFY, That I attended deceased from Apr 2, 1927, to Apr 4, 1927, that I last saw h[illegible] alive on Apr 4, 1927, and that death occurred, on the date stated above, at 5:00 P m.

The CAUSE OF DEATH* was as follows:

Generalized tuberculosis primary in Peritoneum

(duration) Nat'l Course yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. 15 mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. A. Thompson M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Greenmount | 6/6 1927 |
| 20 UNDERTAKER Wm Cook | ADDRESS 207 E Madison |

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20924

## CERTIFICATE OF DEATH.

E 20924

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital ST. 25-73 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. William Urban

(a) RESIDENCE NO. English Consul Md ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | married |

5a If married, widowed, or divorced HUSBAND of or) WIFE of Adele Urban

6 DATE OF BIRTH (month, day, and year) July 31, 1815

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 51 | 10 | 3 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Adele Urban

(Address) English Consul - Md

15 Filed APR 6 1927 C. HAMPTON JONES, M. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-4-1927

17 I HEREBY CERTIFY, That I attended deceased from 3-26, 1927, to 4-4, 1927,

that I last saw him alive on 4-4, 1927,

and that death occurred, on the date stated above, at 1250 P m.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Cystitis, benign prostatic hypertrophy (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of April 3, 1927

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Theron Hunter, M. D.

4/7, 1927 (Address) St. Agnes' Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Cathedral

DATE OF BURIAL Apr 7 1927

UNDERTAKER W. Cook

ADDRESS 502 E Monument

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20925

## CERTIFICATE OF DEATH.

90 E 20925

REGISTERED NO._____

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS [redacted] 76-27

City of BALTIMORE: (No._____ St._____ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fred Brown

(a) RESIDENCE NO. BALTIMORE CITY HOSPITALS St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Divorced |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) May 1856

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 70 71 | 11 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) New Hampshire

PARENTS

10 NAME OF FATHER Timothy Brown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) N. H.

12 MAIDEN NAME OF MOTHER Martha ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) N. H.

BALTIMORE CITY HOSPITALS

Informant

(Address) [redacted]

15 Filed_____ 19 HAMPSON JONES M. D.

Registrar

For RM

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 1927

17

I HEREBY CERTIFY, That I attended deceased from February 23 1927, to April 5, 1927,

that I last saw h[redacted]alive on April 5, 1927

and that death occurred, on the date stated above, at 11 5/4 m.

The CAUSE OF DEATH* was as follows:

Arterial Sclerosis

Chronic Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) yrs. mos. 7 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? general & Laboratory

(Signed) Hoopie Smith, M. D.

April 5 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Date of Burial Apr 7 1927

20 UNDERTAKER W. M. Cook ADDRESS 507 E Madison St.

APR 6 1927

Be sure that all items are answered, as this is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 20926

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20926

## CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2260 Linden Ave. St. 13-59 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Miller

(a) RESIDENCE NO. 2260 Linden Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | white | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Becky Miller

6 DATE OF BIRTH (month, day, and year) April 15-1868

| 7 AGE | Years | Months | Days 21 | If LESS than 1 day, ..... hrs. or min. |
|---|---|---|---|---|
| | 63 | 10 11 | 22 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant 045

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Michael Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Etta —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Benj. T. Miller

(Address) 1550 Penna. Ave.

15 Filed ..... 19 .....

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-6- 1927

17

I HEREBY CERTIFY, That I attended deceased from 12/10, 1926, to 4/6, 1927.

that I last saw him alive on 4/6, 1927

and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) I. A. Ginberg, M. D.

4/6, 1927 (Address) 2026 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Mt. Lebanon Cemetery | 4/6 1927 |
| 20 UNDERTAKER | ADDRESS |
| Jack Lewis | 1439 E. Baltimore St. |

TION is very important. See instructions on back of certificates.

6 1927 C. HAMPSON JONES, M. D.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20927

## CERTIFICATE OF DEATH.

E 20927
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1606 E Pratt St 3-4 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michael Y. Cohen

(a) RESIDENCE No. 1606 E. Pratt St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? 19 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Cohen

6 DATE OF BIRTH (month, day, and year): 1850

7 AGE: Years 77 Months 6 Days 19 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Dresser
(b) General nature of industry, business, or establishment in which employed (or employer): Retired
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country): Russia

PARENTS

10 NAME OF FATHER: Yekuiel Cohen
11 BIRTHPLACE OF FATHER (city or town) .....
(State or country): Russia
12 MAIDEN NAME OF MOTHER: Unknown
13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country): Russia

14 Informant: Harry Cohen
(Address): 1607 N. Fairmount Ave

15 Filed ..... 19 ..... Registrar

APR 6 1927

C. HAMPSON JONES, M. D.

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 9 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:
Acute Dilation of Heart
Hypertension & myocarditis
Sudden
(duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary) arterio-Sclerosis
(duration) 4 yrs. 2 mos. ds.

(Signed) James M Benton M. D.
(Coroner)
4/4, 1927 (Address) York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the state ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale — Date of Burial: 4/6 1927

20 UNDERTAKER: Jack Levin — ADDRESS: 1439 Eastern

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20928

90

## CERTIFICATE OF DEATH.

E 20928
REGISTERED NO.

1-PLACE OF DEATH Sinai Hospital

City of BALTIMORE: (No. ____ St. 3-5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annette Weinstein

(a) RESIDENCE NO. 1119 E. Balt. St. St. ____ Ward ____
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? 40 yrs. ____ mos. ____ ds.
(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Barnett Weinstein

6 DATE OF BIRTH (month, day, and year): 1871

7 AGE — Years: 56 — Months: — — Days: — — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town):
(State or country): Russia

PARENTS

10 NAME OF FATHER: Harris Laik

11 BIRTHPLACE OF FATHER (city or town):
(State or country): Russia

12 MAIDEN NAME OF MOTHER: Bessie

13 BIRTHPLACE OF MOTHER (city or town):
(State or country): Russia

14 Informant: Mrs. Weinstein
(Address): 1119 E. Balt St.

Date Filed APR. 6 1927 J. HAMPSON JONES, M. D.
Per ____ Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 5 1927

17 I HEREBY CERTIFY, That I attended deceased from April 3, 1927, to April 5, 1927, that I last saw her alive on April 5, 1927, and that death occurred, on the date stated above, at 1 p.m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
Cardiac failure

(duration) ____ yrs. ____ mos. 2 ds.

CONTRIBUTORY (Secondary): Hypertension
Chronic myocarditis
(duration) Years ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of ____

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) John Aaron Aaron, M. D.
4/5, 1927 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Mt. Carmel — Date of Burial: 4/6, 1927

20 UNDERTAKER: Jack Levin — ADDRESS: 1434 E. Balt St

Very important. See instructions on back of certificates. Exact statement of OCCUPATION is necessary in all cases, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20929 CERTIFICATE OF DEATH. 45-23 129 E 20929

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1303 Presstman ST. (WARD)

REGISTERED NO.

4 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Ann Dennis

(a) RESIDENCE NO. 1303 Presstman ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | Colored | Widowed |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James H. Dennis

6 DATE OF BIRTH (month, day, and year) May 7, 1868

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 58 | 11 | 26 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) Undertaker

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) West River Md.

PARENTS

10 NAME OF FATHER John Andrew Matthews

11 BIRTHPLACE OF FATHER (city or town) (State or country) West River Md.

12 MAIDEN NAME OF MOTHER Carolyn A Thom

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West River Md

14 Informant Harriett Turner

(Address) 1303 Presstman St

15 Filed APR 6 1927 C. HAMPSON JONES, M. D. Registrar

Per

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 28, 1926, to April 3, 1927, that I last saw her alive on April 3, 1927 and that death occurred, on the date stated above, at 2-30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema (Cardiac Failure ½)

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis ?

(duration) 1 ½ yrs. ? mos. ds.

18 Where was disease contracted if not at place of death? 1303 Presstman

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Thos. N. Mudd, M. D.

4/3, 1927 (Address) 1309 Presstman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL April 7 1927

20 UNDERTAKER Thomas G. Nelson.

ADDRESS 1303 Presstman

CAUSE OF DEATH to be plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Fortune

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20930 — E 20930

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) George M. Fortune St.) 19-54 (WARD) 1-00

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME 2229 Ethring St

(a) RESIDENCE NO. 2229 Ethring St. (Ethring St) WARD
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. V mos. V ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 19th. 1926

7 AGE — Years: 1 — Months: V — Days: 19 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): 2229 Ethring St. Balt Md.

PARENTS

10 NAME OF FATHER: Melvin Fortune

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Mildred Brooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Melvin Fortune 2229 Ethring St

15 Filed APR - 6 1927 — HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/31 1927

17 I HEREBY CERTIFY, That I attended deceased from 3/30 1927 to 4/31 1927

That I last saw h[illegible]live on 4/31 1927

and that death occurred, on the date stated above, at 11. [illegible]

The CAUSE OF DEATH* was as follows: Bronchial Pneumonia

(duration) yrs. — mos. V ds.

CONTRIBUTORY (Secondary): Influenza Diphtheria

(duration) yrs. — mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Lee Ellis, M. D.

(Address) 4 W. Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Cemetery — DATE OF BURIAL: April 6 1927

20 UNDERTAKER: Thomas E. Kelson. — ADDRESS: 1303 Pressman St

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

261 3857 E 20931

## CERTIFICATE OF DEATH.

100-001 E 20931

1-PLACE OF DEATH

REGISTERED NO._____

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elsie E. Patterson

(a) RESIDENCE NO. 5 N. Exeter St. St.____ Ward____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yr. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 2 1927

7 AGE: Years | Months 2 mths. 3 | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER John Patterson

11 BIRTHPLACE OF FATHER (city or town) —

(State or country)

12 MAIDEN NAME OF MOTHER Hetty Patterson

13 BIRTHPLACE OF MOTHER (city or town) —

(State or country)

11 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed____ 19____ Per____ Registrar

R 6 1927 C. HUMPSON JONES, M. D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 1927

17

I HEREBY CERTIFY, That I attended deceased from Mar 22 1927, to April 5 1927, that I last saw her alive on April 5 1927, and that death occurred, on the date stated above, at 9 40 m.

The CAUSE OF DEATH* was as follows:

Otitis Media

Broncho Pneumonia 5

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Intracranial Hemorrhage

(duration) yrs. mos. 18 ds.

18 Where was disease contracted (if not at place of death) Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Physical Examination

(Signed) Thomas W. Cornell, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Hampden — Date of Burial: Apl 7 1927

20 UNDERTAKER: Chenowith & Son — ADDRESS: 3617 Chestnut Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of the CAUSE OF DEATH is very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

E 20932

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

160 ✓

E 20932

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 3434 Cedar Ave. St. 13-52 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis W. West

(a) RESIDENCE NO. 3434 Cedar Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4yrs. mos. da. How long in U. S. if of foreign birth? yrs. mos. da.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 5, 1927.

7 AGE — Years — Mos. 1 — Days — IF LESS than 1 day ____hrs. or ____min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): md.

(State or country)

PARENTS

10 NAME OF FATHER: Kenneth West

11 BIRTHPLACE OF FATHER (City or town): md

(State or country)

12 MAIDEN NAME OF MOTHER: Oda Young.

13 BIRTHPLACE OF MOTHER (city or town): md.

(State or country)

14 Informant: Kenneth West.

(Address) 3434 Cedar Ave.

15 Filed APR 6 1927 C. HAMPSON JONES, M. D. Registrar

Per R.R.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 5, 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 5 1927 to Apr 5 1927.

that I last saw him alive on Apr 4 1927

and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows: Examination

(duration) ____yrs. 1 mos. ____da.

CONTRIBUTORY (Secondary)

(duration) ____yrs. ____mos. ____da.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Louis W. West, M. D.

4/6 1927 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| St. Marys Hampden | April 6, 1927 |
| 20 UNDERTAKER | ADDRESS |
| Chenoweth Son. | 3615 Chestnut Ave |

OR - 6 1927

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20933

## CERTIFICATE OF DEATH.

1 PLACE OF DEATH E 20933

REGISTERED NO. 129

CITY OF BALTIMORE: (No. 600 East Eager Street 10-15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Neville

(a) RESIDENCE NO. 600 E. Eager Street ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Michael J. Neville

6 DATE OF BIRTH (month, day, and year): Mar. 17, 1859

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 68 | 0 | 18 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Wexford Ireland

PARENTS

10 NAME OF FATHER: Edw. Connelly

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Cath. Holden

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Daughter

(Address) 633 E. Eager St.

15 Filed APR 6 1927 19 H. HAMPSON JONES, M. D. Registrar

Per RJC

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 5 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar. 28, 1927, to April 5, 1927

that I last saw her alive on April 4, 1927

and that death occurred, on the date stated above, at 10-10 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(duration) 6 yrs. mos ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. 24 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Urinalysis -

(Signed) Mary F. Coughlin M. D.

4.6. 19 (Address) 1028 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral

DATE OF BURIAL: 4/8 1927.

20 UNDERTAKER: Rita Wiedefeld

ADDRESS: 914 Fremont Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

20934

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20934

## CERTIFICATE OF DEATH

1-PLACE OF DEATH 1700 Eutaw Place

REGISTERED NO.

City of BALTIMORE: (No. Navarre Apts. St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isidore Ask

(a) RESIDENCE NO. 1700 Eutaw Place St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harriet N. Ask

6 DATE OF BIRTH (month, day, and year) Oct. 15, 1854

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..hrs. or ..min.. |
|---|---|---|---|---|
| | 72 | 11 | 20 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Louis Ask

11 BIRTHPLACE OF FATHER (City or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Emma Guttman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. D. Ask (Address) 3201 Harrison Ave.

15 Filed APR - 6 1927 19 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/5/1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 3d, 1927, to April 4, 1927, that I last saw h[im] alive on April 5th, 1927, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Endocarditis, Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema of lungs Arteriosclerosis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted at home

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Joseph L. Goldman M. D.

4/6/27 (Address) 3761 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Har Sinai Cem. Date of Burial 4/7/ 192[7]

20 UNDERTAKER Harry Sondheim ADDRESS 1[8]20 W. Fay. Bal[to]

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20935

## CERTIFICATE OF DEATH.

E 20935

1-PLACE OF DEATH Mercy Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. ) ST. 47 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mattie Thomas

(a) RESIDENCE NO. 2301 Rivermont Ave. Lynchburg Va.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F. | W. | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1875

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs or ....min. |
|---|---|---|---|---|
| | 52. | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Record (Address) C. HAMPSON JONES, M. D.

15 Filed APR 6 1927 Per R. F. C. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 5 1927.

17 I HEREBY CERTIFY, That I attended deceased from Feb. 13, 1927, to April 5, 1927.

that I last saw h alive on April 5, 1927

and that death occurred, on the date stated above, at 10.25 P. m.

The CAUSE OF DEATH* was as follows:

Influenza -
Phlebitis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) C. Hampson Jones M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Lynchburg Va | 4/6/27 |
| UNDERTAKER | ADDRESS |
| Lynch Funeral Service | Lynchburg Va |

SEE INSTRUCTIONS very important See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 20936

# HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 20936

## CERTIFICATE OF DEATH.

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 2044 Linden St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Green

(a) RESIDENCE NO. 440 Pinkney Place Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | W. | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John H Green

6 DATE OF BIRTH (month, day, and year) March 22 57

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 70 | 0 | 12 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home work

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) Balto

PARENTS

10 NAME OF FATHER Kenhen

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Germany

14 Informant John H Green

(Address) 2044 Linden

15 Filed_____, 19_____ C. HAMPSON JONES, M. D.

Per _____ Registrar

R 6 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 April 4

17

I HEREBY CERTIFY, That I attended deceased from Feby 8, 1927, to Apr 4, 1927

that I last saw alive on Apr 3, 1927

and that death occurred, on the date stated above, at 2.45 P.m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilitation

(duration) ____yrs. ____mos. 1 ds.

CONTRIBUTORY (Secondary) Arteri Endocarditis

(duration) 1 yrs. ____mos. ____ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Paul Bunn, M. D.

4/4 1927 (Address) 1537 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery Date of Burial April 7 1927

20 UNDERTAKER H M Rockwell ADDRESS 2238 N North

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20937

## CERTIFICATE OF DEATH

90 E 20937

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2402 Fait Ave St. 1-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME MICHAEL KWIATKOWSKI,

(a) RESIDENCE NO. 2402 Fait Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 51 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? 51 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Victoria Kwiatkowski,

6 DATE OF BIRTH (month, day, and year) August 19-1872.

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|---|
| | 54 | 7 | 16 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Day laborer, 04

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Poland,

PARENTS

10 NAME OF FATHER Martin Kwiatkowski,

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Poland,

12 MAIDEN NAME OF MOTHER Unknown,

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland,

14 Informant Victoria Kwiatkowski, (Wife)

(Address) 2402 Fait Ave

15 Filed APR 6 1927 19 C. HAMPSON JONES, M. D. Registrar

By RK

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 16, 1927, to April 4, 1927,

that I last saw him alive on April 1, 1927,

and that death occurred, on the date stated above, at 5 30 P m.

The CAUSE OF DEATH* was as follows:

Cerebro spinal Lues

3

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

3

(duration) 2 yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symps

(Signed) Clark Fellers, M. D.

4/5/, 19 27 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus. Date of Burial Apr. 7 1927

20 UNDERTAKER F. Sadowski. ADDRESS 705 S Ann

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20938

## CERTIFICATE OF DEATH.

31 ✓ E 20938

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 1707 S. Ann St., 2-4 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martin Poladowski

(a) RESIDENCE NO. 1707 S. Ann St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | white | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 12 1898.

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 28 | 5 | 28 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Lucas Bros

(c) Name of employer 066

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER Frank Poladowski

11 BIRTHPLACE OF FATHER (city or town) Poland

(State or country)

12 MAIDEN NAME OF MOTHER Mary Drzmala

13 BIRTHPLACE OF MOTHER (city or town) Poland

(State or country)

14 Informant Mrs. Mary Poladowski Wife

(Address) 1707 S Ann

15 Filed....., 19 C. HAMPSON JONES, M. D.

Registrar

APR 6 1927

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4 1927.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows: Cerebral hemorrhage due to tuberculosis

Acute 4 days (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Apr 4 Signed M. F. Dado (Coroner) M. D.

, 19 27 (Address) 1639 Linden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus. Date of Burial Apr. 8. 1927

20 UNDERTAKER M. F. Dadowski. ADDRESS 705 S. Ann St.

If DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

Hardy

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20939

## CERTIFICATE OF DEATH.

A 188-003

E 20939

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Union Protestant St. 420 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herbert Arnold Hardy

(a) RESIDENCE NO. 15 Gough St. St. Wards

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 31, 1901

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 26 | 7 | 4 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fish Selling

(b) General nature of indnstry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Phila Pa

(State or country)

PARENTS

10 NAME OF FATHER John Hardy

11 BIRTHPLACE OF FATHER (city or town)

(State or country) England

12 MAIDEN NAME OF MOTHER Emily Follett

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) England

14 Informant Father

(Address)

Filed 8 1927 19 C. HAMPSON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4 5 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental accident Struck with Falling Trumpet Fractured Skull

(duration) yrs. mos. ds.

CONTRIBUTORY Meningitis

(Secondary)

(duration) yrs. mos. ds.

(Signed) Harold Wiseman M. D.

(Coroner)

, 19 27 (Address) 825 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem Date of Burial Jan 7 1927

20 UNDERTAKER John Ullrich ADDRESS 2008 Ore

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 20940

E 20940

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Providence Hospital St. 15-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Harvey

(a) RESIDENCE NO. 1362 Whatcoat St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX male

4 Color or Race colored

5 Single, Married, Widowed, or Divorced. (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of ~~[illegible]~~ Dora Harvey

6 DATE OF BIRTH (month, day, and year) Oct. 7, 1879

7 AGE Years 47 Months 48 Days 5 29 27

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bus Driver

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) North Carolina

PARENTS

10 NAME OF FATHER Charles Harvey

11 BIRTHPLACE OF FATHER (City or town)

(State or country) North Carolina

12 MAIDEN NAME OF MOTHER Julia Atwater

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) North Carolina

14 Informant William Harvey

(Address) 1362 Whatcoat Ste

15 Filed APR - 6 1927 C. HAMPSON JONES, M. D. Registrar Per RK

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4 19 27

17 I HEREBY CERTIFY, That I attended deceased from Mar. 27 19 27 to April 4 19 27

that I last saw h.. alive on April 4 19 27

and that death occurred, on the date stated above, at 10.05 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Inoperable)

(duration) Unknown yrs. Mos. ds.

CONTRIBUTORY (Secondary) Anemia

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) John W. Gaines, M. D.

, 19 (Address) Providence Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Cemetery — Date of Burial 4/6/27

20 UNDERTAKER Thomas E. Kelton — ADDRESS 1303 Pennsylvania Ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26 [illegible]

E 20941

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

129 E 20941

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1335 Aisquith St. 9-18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John T. Gaffey

(a) RESIDENCE NO. 1335 Aisquith St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Gaffey

6 DATE OF BIRTH (month, day, and year) May 1 1860

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min.. |
|---|---|---|---|---|
| | 66 | 11 | 4 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk People's Court

(b) General nature of industry, business, or establishment in which employed (or employer) City of Baltimore

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.

(State or country)

PARENTS

10 NAME OF FATHER Michael Gaffey

11 BIRTHPLACE OF FATHER (City or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Annie Gaffey

(Address) 1335 Aisquith St.

APR 6 1927 Filed ... 19... C. HAMPSON JONES, M. D. Registrar

Per [illegible]

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

April 5, 1927

17 I HEREBY CERTIFY, That I attended deceased from August, 1926, to April 5, 1927, that I last saw h. alive on April 4, 1927, and that death occurred, on the date stated above, at 3 N. A. m.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Hubert G. Knapp, M. D.

Apr 5, 1927 (Address) 1216 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

Date of Burial 4/8 1927

20 UNDERTAKER [illegible] ADDRESS [illegible]

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 20942

151 E 20942

E 20942

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 9-50 WARD)

2-FULL NAME Frank M. Keever.

(a) RESIDENCE NO. 523 East 21st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. dys. How long in U. S., if of foreign birth? yrs. mos. dys.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word) |
|---|---|---|
| Male | White | married. |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie M. McKeever

6 DATE OF BIRTH (month, day, and year) Sept 1863

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 63 | 7 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John M. McKeever

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Annie Regan McKeever

(Address) 523 E. 21st St

15 Filed APR 6 1927, 19 C. HAMPSON JONES, M.D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 1927.

17

I HEREBY CERTIFY, That I attended deceased from April 2, 1927. to April 5, 1927.

that I last saw h~~i~~m alive on April 5, 1927;

and that death occurred, on the date stated above, at 9 45 P m.

The CAUSE OF DEATH* was as follows:

Toxemia - Cardiac Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Gangrene of Left leg - (duration) — yrs. 3 mos. — ds.

18 Where was disease contracted if not at place of death? at Residence

Did an operation precede death? No Date of No.

Was there an autopsy? No.

What test confirmed diagnosis? Clinical & Laboratory

(Signed) James W. Nelson M. D.

, 19 (Address) Mercy Hospt.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 4/9 19 27

20 UNDERTAKER Chas. P. Crane & Son

ADDRESS 118 W. Mt. Royal Ave

TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

Alice T. Williams

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 20943

1-PLACE OF DEATH

REGISTERED NO. E 20943

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL 14-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Tucker Williams

(a) RESIDENCE NO. 1412 Myrtle Avenue St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Mar

5a If married, widowed, or divorced (or) WIFE of: Charles Williams

6 DATE OF BIRTH (month, day, and year): 1904

7 AGE: Years 23; Months; Days; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Stoney Creek

(State or country): Virginia

PARENTS

10 NAME OF FATHER: Louis Tucker

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Virginia

12 MAIDEN NAME OF MOTHER: Minnie Shands

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Va

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

APR - 6 1927 By RH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 5 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr 4, 1927, to April 5, 1927, that I last saw h[illegible] alive on Apr 5, 1927, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Streptococcus peritonitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary): Rupture of tubo-ovarian abscess

(duration) 1 yrs. mos. ds.

18 Where was disease contracted (if not at place of death)? In Baltimore.

Did an operation precede death? No Date of .

Was there an autopsy? Yes

What test confirmed diagnosis? Culture of Smear

(Signed) Robt L. Faulkner, M. D.

4-6, 1927 (Address) JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Stoney Creek Va

Date of Burial: Apr 7 1927

UNDERTAKER: Sam't H. Chase Sons

ADDRESS: 1405 Madison

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 20944

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1927 S 90 E 20944

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 710 N. Collington Ave. St. 8-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Libzetta R. Mueller

(a) RESIDENCE NO. 710 N. Collington Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? 6 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | White | Married |

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of Rud H. Mueller

6 DATE OF BIRTH (month, day, and year) Apr. 12 - 1864

| 7 AGE | Years | Months | Days | IF LESS than 1 day ... hrs. or ... min. |
|---|---|---|---|---|
| | 57 | 11 | 23 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER August Reer

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ger.

12 MAIDEN NAME OF MOTHER Pauline Nee Brown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ger.

14 Informant Mrs Marie E. Mueller

(Address) 1702 Collington Ave

15 Filed APR - 6 1927 HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 4, 27 19

17 I HEREBY CERTIFY, That I attended deceased from Nov. 15 1926, to Apr. 4 1927, that I last saw h[illegible] alive on Mch 30, 1927, and that death occurred, on the date stated above, at [illegible] p. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage due to Epithelial Cancer of [illegible]

(duration) yrs. four months ds.

CONTRIBUTORY (Secondary) Cancer of Ut. Hernia with Tolerable Dis. of Heart

(duration) 6 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Consultation

(Signed) E. H. Brack, M. D.

Apl. 4 1927 (Address) 1605 N. Rock Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery Date of Burial 4/7 1927

20 UNDERTAKER C. V. Fanning Son ADDRESS 1986 Lafayette Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E·20945

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20945

## CERTIFICATE OF DEATH.

188-003

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Sq. Hosp. St., 19 Ward)

REGISTERED NO

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Paul M. Lewis

(a) RESIDENCE NO. 2671 Pennsylvania Ave Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. — mos. — ds. How long in U. S., if of foreign birth? 65 yrs. — mos. — ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widower |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Apr 27 1852

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 74 | 11 | 8 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant Sailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town)

(State or country) Ireland

PARENTS

10 NAME OF FATHER Wm Lewis

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Brodick

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Esther Kilbaugh

(Address) 2671 Pennsylvania Ave

Date 1927 C. HAMPSON JONES, M. D.

Per Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 4 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry) thereon and from the evidence obtained Investigation find that said deceased came to his death (autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH was as follows: Multiple Fract ribs both sides - Hemorrhage Lungs due to punctured Lungs 4 hours (duration)

CONTRIBUTORY (Secondary) Struck by Automobile (Coroner)

(Signed) Thos. B. Horton M. D.

(Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Vincent's Cemetery Date of Burial 4/7 1927

20 UNDERTAKER Henry W. Spears & Son ADDRESS 805 N. Calvert

OF DEATH In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20946

E 20946

## CERTIFICATE OF DEATH.

100-081

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1518 Aisquith St. St. 14 20 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert Jones

(a) RESIDENCE NO. 1518 Aisquith St St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | colored | single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) about Dec. 14, 1924

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | | 3 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) Virginia

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant K. W. Dietz, Policeman, (Address) Penna Ave.

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

3285

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.

thereon and from the evidence obtained by said Inquest, autopsy or inquiry. find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Acute Otitis Media

(duration) yrs. mos. ds.

(Signed) C. H. Jones M. D.

(Coroner)

March 14, 1927 (Address) 2502 Kenwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 19

20 UNDERTAKER ADDRESS

UNIVERSITY OF MARYLAND

Commissioner Health

APR 6 1927

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8 MONDAY

(Spec. 7-17-26—A Co.—200 Bks.

E 20947

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20947

## CERTIFICATE OF DEATH

101-8 X

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Provident Hosp. St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Fuller

(a) RESIDENCE NO. Sparrows Point Md St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: unknown

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE Years: 23 Months: Days: IF LESS than 1 day.....hrs. or....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): unknown

(State or country)

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant

(Address)

15 Filed 6 1927 By C. HAMPSON JONES, M. D. Registrar

1234

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-27-1927

17 I HEREBY CERTIFY, That I attended deceased from 2-18, 19 27, to 3-27, 19 27, that I last saw h— alive on 3-27, 19 27, and that death occurred, on the date stated above, at 2:50 P m.

The CAUSE OF DEATH* was as follows:

Emphysema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. 1 mos. 7 ds.

18 Where was disease contracted

If not at place of death? Sparrows Point

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Enumeration

(Signed) Frank C. Saunders, M. D.

, 19 (Address) 1029 N. Stricker St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

Date of Burial 19

20 UNDERTAKER: Commissioner of Health

ADDRESS

THE MORGUE

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Fulghum)

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20948

## CERTIFICATE OF DEATH.

E 20948

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 532 N Central Ave St.) (5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo L. Fulghum

(a) RESIDENCE NO. 1333 N Gilmor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of [illegible] Alice R. Fulghum

6 DATE OF BIRTH (month, day, and year) Jan 14, 1887

7 AGE: Years 40 Months 2 Days 20 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Construction

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry Fulghum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant (Address) Alice R Fulghum wife 1333 Gilmor st

15 C. HAMPSON JONES, M. D. 19 ... Registrar

6 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb . 1927 . to April 4 . 1927 .

that I last saw h[illegible] alive on March 31 . 1927 .

and that death occurred, on the date stated above, at 11 30 p. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac dilitation

(duration) yrs. mos. 1 hr

CONTRIBUTORY (Secondary) Mitral Regurgitation and stenosis (duration) yrs 2 mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R J Young M. D.

4/6 1927 (Address) 1420 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem- DATE OF BURIAL: Apr. 8 1927

20 UNDERTAKER: Mrs J. G. Locke ADDRESS: 1312 Jeff.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

20949

## CERTIFICATE OF DEATH.

100-001

E 20949

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 289 W. 31 St. St., 12-51 Ward)

2-FULL NAME Mary Jane O'Donnell

(a) RESIDENCE NO. 289 W. 31 St St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE: Years: about 70 | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): old

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Balto. Co. Md.

PARENTS

10 NAME OF FATHER David O'Donnell

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary McCaffery

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Ireland

14 Informant Mr. E. T. Kernan

(Address) 701 Winston Ave.

15 Filed 6 1927 C. HAMPSON JONES, M. D. Registrar

Per _____

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

April 4 1927

17

I HEREBY CERTIFY, That I attended deceased from March 15, 1927, to April 4, 1927, that I last saw her alive on April 4, 1927, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

Old age (duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? _____

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? Stethoscope

(Signed) E. T. Kernan, M. D.

4-6-1927 (Address) 2104 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem. Date of Burial: 4/7/27 19

20 UNDERTAKER: Mary M. Riedefeld ADDRESS: 501 E. 25th St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20950

## CERTIFICATE OF DEATH.

E 20950

1-PLACE OF DEATH

City of BALTIMORE: (No. 600 Aldersgate St. Ward) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry E. Stegman

(a) RESIDENCE NO. 600 Aldersgate St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 Color or Race White | 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 6 1884

7 AGE Years 42 Months 7 Days 30 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Asst Painter

(b) General nature of industry, business, or establishment in which employed (or employer) 050

(c) Name of employer

9 BIRTHPLACE (city or town) Penna

(State or country)

PARENTS

10 NAME OF FATHER Fred M Stegman

11 BIRTHPLACE OF FATHER (city or town) Germany

(State or country)

12 MAIDEN NAME OF MOTHER Barbara Bickmyer

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs Carl Hoenig (Address) 600 Aldersgate St

15 Filed 6 1927 C. HAMPSON JONES, M. D. Registrar

By

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull (accidental) 4 hrs.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) struck by automobile.

(duration) yrs. mos. ds.

(Signed) J. J. Neumeyer, M. D. (Coroner)

April 5, 1927 (Address) 2502 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem Date of Burial 4/7/27

20 UNDERTAKER Fisk Stanley Fulton & Fayette ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20951

CERTIFICATE OF DEATH.

X 86-002

E 20951

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 7-9 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alden Penry

(a) RESIDENCE NO. 835 Jersey Ave Winston Salem Ward N.C.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): April 22-1891

7 AGE: Years 35 36 | Months 11 - | Days 14 6 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Advertising Manager

(b) General nature of industry, business, or establishment in which employed (or employer): Tobacco Co - 80

(c) Name of employer: R. J. Reynolds

9 BIRTHPLACE (city or town)

(State or country): N.C.

PARENTS

10 NAME OF FATHER: C. F. Penry

11 BIRTHPLACE OF FATHER (city or town)

(State or country): N.C

12 MAIDEN NAME OF MOTHER: Alice Lee

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): N.C.

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed APR 6 1927 C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: April 6-1927

17 I HEREBY CERTIFY, That I attended deceased from 4/5/27, 19, to 4/6/27, 19,

that I last saw him alive on 4/6/27 9:00 A.M. 19,

and that death occurred, on the date stated above, at 10:10 A.M.

The CAUSE OF DEATH* was as follows:

abscess temporal lobe of brain

following mastoid operation

2 wks (?) (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

— (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Home.

Did an operation precede death? Yes Date of 4/5/27.

Was there an autopsy? no.

What test confirmed diagnosis? Exploratory Cerebral puncture.

(Signed) George G. Turner, M. D.

4/6/1927 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Winston Salem N.C. Date of Burial: Apr 6 1927

20 UNDERTAKER: C. Barton ADDRESS 5 N. Northern Parkway

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

20952

## CERTIFICATE OF DEATH

31 E 20952

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 949 Homestead St., 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie M. George

(a) RESIDENCE NO. 949 Homestead St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. 11 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry M. George

6 DATE OF BIRTH (month, day, and year) May 25, 1902

| 7 AGE | Years | Months | Days | If LESS than 1 day hrs. or min.. |
|---|---|---|---|---|
| | 25 | 11 | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Richard B. Sparks

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Balto. county

12 MAIDEN NAME OF MOTHER Virginia Dillahunt

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto. Md.

14 Informant Mrs. Richard Sparks

(Address) 949 Homestead St.

15 Filed C. HAMPSON JONES, M. D. Registrar

APR 6 1927 Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3 1927

17 I HEREBY CERTIFY, That I attended deceased from August 15, 1926, to April 3, 1927, that I last saw h alive on April 2, 1927, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos ds.

18 Where was disease contracted if not at place of death? Do not know

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Laboratory

(Signed) L. L. Scully, M. D.

4-5, 1927 (Address) 4218 Harford Rd

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's (Govans) Date of Burial April 7, 1927

20 UNDERTAKER Richard F. Curley ADDRESS 608 N. Bway

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 20953

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20953

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1426 Riviersdale Ave St. 24-34 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilhelmina Froehlich

(a) Residence No. 1426 Riviersdale Ave St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos ds How long in U. S., if of foreign birth? yrs. mos. ds

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Adolph Froehlich

6-DATE OF BIRTH (month, day and year) July 4th 1852

7-AGE. 74 yrs. 9 mos. 1 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. House Work

(b) General nature of industry, business, or establishment in which employed (or employer). 037

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS:

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Elizabeth Froehlich

(Address) 1426 Riviersdale Ave

15- Filed 6 1927 C. HAMPSON JONES, M. D. Registrar.

Per Bell

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 5th 1927

17. I HEREBY CERTIFY, That I attended deceased from March 21 1927 to April 6 1927

that I last saw h alive on April 4 1927

and that death occurred, on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. mos 10 ds

CONTRIBUTORY (Secondary) La Grippe

(Duration) yrs. mos 15 ds

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Hamilton Willis M. D.

19 (Address) 610 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cedar Hill Cem. DATE OF BURIAL. April 7th 1927

20-UNDERTAKER. E Schlosman & Son ADDRESS 1034 Hanover St

Instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20954

## CERTIFICATE OF DEATH.

90

E 20954

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1302 N. Gay ST., 8-17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles B. Potter

(a) RESIDENCE NO. 1302 N. Gay ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Barbara M. Potter

6 DATE OF BIRTH (month, day, and year) Aug. 7-1854

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min |
|---|---|---|---|---|
| | 72 | 7 | 27 28 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Patrolman

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 061

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Thomas Potter

11 BIRTHPLACE OF FATHER (city or town) (State or country) dont know

12 MAIDEN NAME OF MOTHER Sarah Levy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) dont know

14 Informant Barbara M. Potter

(Address) 1302 N. Gay St.

15 Filed 6 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1927 to April 4-27 that I last saw h alive on April 4 1927 and that death occurred, on the date stated above, at 4.40 P. m

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Fra Blendon, M. D.

(Address) 1002 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery — DATE OF BURIAL April 7 1927

20 UNDERTAKER Zirkler & Zirkler — ADDRESS 1739 E. Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

R - 6

Cor.—1-12-23—M&T—100 Bks.

E 20955

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20955

## CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No.) 2240 Guilford avenue St. 17-19 (WARD)

2-FULL NAME William E. Kelley.

(a) RESIDENCE No. 2010 N. Calvert St., ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male. | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Blanche E. Kelley

6 DATE OF BIRTH (month, day, and year) Dec 3, 1884

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 42 | 4 | 2 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Automobile salesman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Oliver Linton Kelley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Francis Alban

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Blanche Kelley (Address) 2010 N. Calvert St

15 Filed 6 1927 G. HAMPSON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/5 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to h death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tabular Disease of Heart

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) H. Louis Kemp, M. D. (Coroner)

4/6, 1927 (Address) 363 Rolandson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Bethel Cemetery Carroll Co, Md | Apr. 8, 1927 |
| 20 UNDERTAKER E. LeRoy Stiffler | ADDRESS 125 E Northern |

How to be very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 20956 (2nd) 684 — E 20956 (1st) X 84

REGISTERED NO.

I-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Gatewood

(a) RESIDENCE NO. 1112 5th St. N.W. Wash. D.C. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): June 22-1909

7 AGE: Years 18 | Months 9 | Days 14 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country) Va.

PARENTS

10 NAME OF FATHER Temple Gatewood

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Va.

12 MAIDEN NAME OF MOTHER Murtle Sharp

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Va.

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

Filed 6 1927 C. HAMPSON JONES, M. D.

By ..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

April 6-1927.

17

I HEREBY CERTIFY, That I attended deceased from Feb 25, 1927, to April 6, 1927, that I last saw h~~im~~ alive on April 6, 19 27, and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

Exacerbation of hydrocephalus

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death!

Did an operation precede death! Yes Date of April 5, 27

Was there an autopsy! Yes

What test confirmed diagnosis! autopsy

(Signed) Warfield M Theobald, M. D.

Apr. 6, 1927 (Address) Johns Hopkins Hospital, Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Washington D C — Date of Burial: 4/8/27

20 UNDERTAKER: Joseph Ahern's — ADDRESS: 221 Bway

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 7-17-26—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

11-001 ✓

E 20957 — 1-PLACE OF DEATH

E 20957 — REGISTERED NO.

City of BALTIMORE: (No. 4425 Pimlico Rd St.) (15-58 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Bernstein

(a) RESIDENCE NO. 4425 Pimlico Rd St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 16, 1914

7 AGE — Years: 13 — Months: 11 — Days: 20 — IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Balto Md.

(State or country)

PARENTS

10 NAME OF FATHER: Adolph Bernstein

11 BIRTHPLACE OF FATHER (City or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Fannie Rothman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Adolph Bernstein

(Address) 4425 Pimlico Rd

15 Filed APR 7 1927 19

HARRISON JONES, M. D.

Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 19 27

17 I HEREBY CERTIFY, That I attended deceased from April 2. 1927. to April 6 1927.

that I last saw her alive on April 6 1927.

and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

Acute Cardiac Dilitation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Irving Sherman, M. D.

(Address) 2051 Riadnos Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Forest dale

Date of Burial: 4/7 1927

20 UNDERTAKER: Sol Levinson & Bro

ADDRESS 1127 E Balto St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. F. Co.—1000 Blks.

Wilenzig

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20958

## CERTIFICATE OF DEATH.

E 20958

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2036 Linden ave St. 14-70 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Meyer Wilenzig

(a) RESIDENCE No. 2036 Linden ave St. Ward

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? 40 yrs. — mos. — ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 68 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Solomon Wilenzig

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Ray Mandelbaum

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Hannah Yousyour 3304 Georgia ave N W Washington D C

15 Filed APR-7 1927, 19 HAMPSON JONES, M. D. Registrar

Per R K

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-5-1927

17 I HEREBY CERTIFY, That I attended deceased from March 20 1927 to April 3 1927 that I last saw him alive on April 3 1927 and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rt. Kidney,

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of Oct Known

Was there an autopsy? No

What test confirmed diagnosis? Dr. Wallerstein

(Signed) John C. Hall M.D.

4/6 1927 (Address) John C. Hall 1344

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL 4/7/27

20 UNDERTAKER Sol Leinson & Bro — ADDRESS 1127 E Balto St.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 20959

90

E 20959

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1051 N Broadway St. 9-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wolf Moses

(a) RESIDENCE NO. 1051 N Broadway Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah

6 DATE OF BIRTH (month, day, and year) 1872

| 7 AGE | Years | Months | Days |
|---|---|---|---|
| | 55 | — | — |

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Realestate

(b) General nature of industry, business, or establishment in whieh employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) Russia (State or country)

PARENTS

10 NAME OF FATHER Milton Moses

11 BIRTHPLACE OF FATHER (City or town) Kriwitsky (State or country) Russia

12 MAIDEN NAME OF MOTHER Thea U.K

13 BIRTHPLACE OF MOTHER (city or town) Russia (State or country)

14 Informant Sarah Moses (Address) 1051 N Broadway

15 Filed ....., 19 .... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 6 / 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Mar 4, 1927, to Apr 6, 1927

that I last saw h alive on Apr. 6, 1927

and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Cardio Renal disease

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation preeede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Nancy L Kittabach M. D.

4/6, 1927 (Address) 1038 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt Carmel Rd Date of Burial 4/7 1927

20 UNDERTAKER A. Levinson & Bro ADDRESS 1127 E Balto St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 20960

1-PLACE OF DEATH

REGISTERED NO. E 20960

City of BALTIMORE: (No. 1430 N. Gay Street St. 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dollie A. Watkins

(a) RESIDENCE NO. 1430 N. Gay Street St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth life yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) 4/13/1908

| 7 AGE Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|
| 18 | 11 | 22 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Milton W. Watkins

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore, Maryland

12 MAIDEN NAME OF MOTHER Dollie Clautice

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Maryland

14 Informant Milton W. Watkins

(Address) 1430 N. Gay Street.

15 Filed APR 7 1927 HARRISON JONES, M. D. Registrar

By

Don should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4 - 5 - 27

17 I HEREBY CERTIFY, That I attended deceased from Feb 15 19 27 to March 5 19 27

that I last saw h[illegible] alive on March 4 19 27

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thos. Spurgin M. D.

(Address) 800 N. Bethesda

4-6-27

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery Date of Burial 4 | 9 1927

20 UNDERTAKER Albert L Hiltz Jr ADDRESS 1606 N. CHESTER

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20961

## CERTIFICATE OF DEATH.

66

E 20961
REGISTERED NO.

1-PLACE OF DEATH Balto City Hospts

City of BALTIMORE: (No. Balto Md S-6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Goldie Miller

(a) RESIDENCE NO. 229 N. High St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Blk | Married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 32 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer

9 BIRTHPLACE (City or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Balto City Hospts

(Address) Balto Md

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

APR - 7 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-4 19 27

17 I HEREBY CERTIFY, That I attended deceased from 4-2- 1927, to 4-4 , 1927

that I last saw h.. alive on 4-3-27 , 19.....

and that death occurred, on the date stated above, at ..... M.

The CAUSE OF DEATH* was (as follows)

Myocardial Failure.
Acute Alcoholic Delirium

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Alcoholic Psychosis Acute
Alcoholic Delirium

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Evidence

(Signed) Harry Goodman M. D.

4/4/1927 (Address) Bolton & City Hospts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Mt. Auburn Cemetery | April 8, 1927 |
| 20 UNDERTAKER | ADDRESS |
| Mrs. Katie R. Williams | N. Schroeder St. |

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20962

## CERTIFICATE OF DEATH.

10-003

E 20962

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital ST., 9-45 WARD)

2-FULL NAME Virginia Lee Crum

(a) RESIDENCE NO. Daughters of Eucharist Paradise Rev. Catonsville ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 19. 1921

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs or ... min. |
|---|---|---|---|---|
| | 5 | 5 | 18 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Clarence Crum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick Md

12 MAIDEN NAME OF MOTHER Phoebe Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Thurmont Maryland

14 Informant (Address) Mrs. Clarence Crum 840 W Fayette St.

15 Filed APR - 7 1927, 19 Per — HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1927

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1927, to April 6, 1927, that I last saw her alive on April 6, 1927, and that death occurred, on the date stated above, at 12 20 P m.

The CAUSE OF DEATH* was as follows:

Nasal Tonsillar Pharyngeal Diphtheria (duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Myocarditis (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Bac. Cult

(Signed) Myron S. Tull, M. D.

4/7 1927 (Address) Sydenham Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lewistown Frederick Co. Md. DATE OF BURIAL April 7 1927

20 UNDERTAKER Chas. S. Black ADDRESS 742 W Pratt ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

90 ✓

E 20963

## CERTIFICATE OF DEATH.

E 20963
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1101 Carey St., 16-23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Harris

(a) RESIDENCE NO. 1101 Carey St. Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Colored | Married |

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of Stephen Harris

6 DATE OF BIRTH (month, day, and year) 1868

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 59? | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 27

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Benjamen Nichols

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Rachel Johnson

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Corine Harris
(Address) 1101 N Carey St

15 Filed ..... 19 ..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 5, 1927, to Apr 6, 1927, that I last saw her alive on Apr 6, 1927, and that death occurred, on the date stated above, at 11:10 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 2? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. 1 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. Williams Trey, M. D.

4/6, 1927 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem April 7 1927

20 UNDERTAKER Hamil Easton ADDRESS 916 Pa Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PR-1927 C. HAMPSON JONES, M. D.

Bar

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

109-002

## CERTIFICATE OF DEATH.

E 20964

E 20964 REGISTERED NO.

1-DATE OF DEATH Bon Secours Hospital

CITY OF BALTIMORE: (No. 16-76 ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Genevieve McGuiness

(a) RESIDENCE No. 513 N. Schroeder ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX female | 4 COLOR OR RACE W | 5 Single, ~~Married, Widowed,~~ or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 2nd 1891

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 35 | 4 3 | 4 2 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Supervisor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Public School

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Mr. P. McGuiness

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary McNamara

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Edgar McGuiness
(Address) 513 N Schroeder St

15 Filed APR - 7 1927 Temporary Receipt HAMPSON JONES M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1927

17 I HEREBY CERTIFY, That I attended deceased from April 5, 1927, to April 6, 1927.

that I last saw her alive on April 6, 1927

and that death occurred, on the date stated above, at 1.45 A m.

The CAUSE OF DEATH* was as follows:

Septicemia - streptococcic with acute tonsilitis

(duration) yrs. (History 4 mos 4 ds.)

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Patholog.

(Signed) Geo. O. Lippay, M. D.

, 19 (Address) Bon Secours Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral | DATE OF BURIAL 3-9-1927

20 UNDERTAKER D. H. Brannigan | ADDRESS 517 N Schroeder St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

Cloth

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 20965

## CERTIFICATE OF DEATH

E 20965

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Provident Hosp. 516 St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Leth

(a) RESIDENCE NO. 1412 E Fayette St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE: Years 76 Months Days

IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer (?)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): unknown

(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) unknown

14 Informant E. M. Stevens

(Address) Easton Md

15 Filed ... 19 ... Registrar

APR - 7 1926

C. HAMPSON JONES, M. D.

Per MORGUE

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4 19 27

17 I HEREBY CERTIFY, That I attended deceased from Mar. 30, 1927, to April 4, 1927

that I last saw h[illegible] alive on April 4, 1927

and that death occurred, on the date stated above, at 5 30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Signs

(Signed) Bernard Harris M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Easton Md — Date of Burial 4/8 192[illegible]

20 UNDERTAKER Samuel Easton — ADDRESS 9½ East

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20966

## CERTIFICATE OF DEATH.

E 20966

31

1-PLACE OF DEATH Balto City Hospt

REGISTERED NO.

City of BALTIMORE: (No. Balto Md St., 24-33 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sidney F. Long

(a) RESIDENCE NO. 1265 Wall St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Amelia Long

6 DATE OF BIRTH (month, day, and year): Nov. 29. 1874

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 53 | 4 | 8 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work:

(b) General nature of industry, business, or establishment in which employed (or employer): Laborer. 0 0

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country) Maryland

PARENTS

10 NAME OF FATHER Sidney Long

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Maryland

14 Informant Balto City Hospts.

(Address) Balto Md

Filed APR-7 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-5 19 27

17 I HEREBY CERTIFY, That I attended deceased from 2-23- 19 27 to 4-5 19 27

that I last saw h living alive on 4-5 19 27

and that death occurred, on the date stated above, at 6.30? m.

THE CAUSE OF DEATH* was as follows:

Pulmonary Tbc & Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Psychosis w/ Pulmonary Tbc

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical findings

(Signed) Harry Goodman M. D.

4/5 19 27 (Address) Balto City Hospts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemtery — Date of Burial April 7 27

20 UNDERTAKER: F. A. Kraemer — ADDRESS 703 Hanover

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 20967

# HEALTH DEPARTMENT—CITY OF BALTIMORE

10-003

## CERTIFICATE OF DEATH.

E 20967

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST., 6-10 WARD)

2-FULL NAME Janet Gossman

(a) RESIDENCE NO. 24 N. Port St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 3, 1922

| 7 AGE | Years | Months | Days 3 | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 4 | 8 | 4 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Frederick Gossman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Cath Schonberger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mrs Fred Gossman

(Address) 24 N Port St

15 Filed ..... 19 ..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar. 25, 1927, to April 6, 1927, that I last saw her alive on April 6, 1927, and that death occurred, on the date stated above, at 7 00 a m.

The CAUSE OF DEATH* was as follows:

Nasal, Tonsillar + Pharyngeal Diphtheria

(duration) yrs. mos 13 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Pos. K L Bd

(Signed) Myron G. Dull, M. D.

19 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Ap. 8 1927

20 UNDERTAKER Geo M Smith Son — ADDRESS 811 N Wolfe

C. HAMPSON JONES, M. D.

Registrar

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20968

## CERTIFICATE OF DEATH.

~~E~~ 20968

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 15-85 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Male Baby Katz

(a) RESIDENCE NO. 4305 Old Pimlico Road Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 hours mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 6 - 1927

7 AGE — Years | Months | Days | IF LESS than 1 day 3 hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ~~and~~

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto city Md

(State or country)

PARENTS

10 NAME OF FATHER Meyer Katz

11 BIRTHPLACE OF FATHER (city or town): Rumania

(State or country)

12 MAIDEN NAME OF MOTHER Rose Golodoff

13 BIRTHPLACE OF MOTHER (city or town): Russia

(State or country)

14 Informant Meyer Katz

(Address) 4305 Old Pimlico Road

15 Filed ..... G. HAMPSON JONES, M. D. Registrar

By RA

APR - 7 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

4-6-27.

17

I HEREBY CERTIFY, That I attended deceased from 4-6, 19 27, to 4-6, 19 27, that I last saw him alive on 4-6, 19 27 and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

atelectasis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis? clinical test

(Signed) Harry Weintraub, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale — Date of Burial 4/7 1927

20 UNDERTAKER: Jack Levis — ADDRESS 1439 E. Baltimore St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20969

## CERTIFICATE OF DEATH.

3/ E 20969

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 21 N. Schroeder ST. 18-26 WARD)

2-FULL NAME Jessie Henderson

(a) RESIDENCE No. 21 N. Schroeder ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? 27 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Henderson

6 DATE OF BIRTH (month, day, and year) June 6 - 1900

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs. or.... min. |
|---|---|---|---|---|
| | 26 | 9 10 | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Bessie Friedman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Freida Farbman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1439 Eastern

15 Filed APR-7 1927, 19 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 21, 1924, to Apr 6, 1927.

that I last saw her alive on Apr 6, 1927

and that death occurred, on the date stated above, at 10 [illegible] m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no

Was there an autopsy? no

What test confirmed diagnosis? Clinic

(Signed) M. Leitzer, M. D.

4/6, 1927 (Address) 1315 Linden.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt Carmel

DATE OF BURIAL 4/7 1927

20 UNDERTAKER Jack Lewis

ADDRESS 1409 Eastern

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20970

## CERTIFICATE OF DEATH.

74-001

E 20970

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor St. 1074 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Cormand

(a) RESIDENCE NO. Preston & Valley St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | ~~Sgl.~~ Widower |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 84 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ireland

(State or country)

PARENTS

10 NAME OF FATHER Maurice Cormand

11 BIRTHPLACE OF FATHER (city or town) Ireland

(State or country)

12 MAIDEN NAME OF MOTHER Mary Casey

13 BIRTHPLACE OF MOTHER (city or town) Ireland

(State or country)

14 Informant Little Sisters of the Poor

(Address)

15 Filed APR - 7 1927 C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 19 27

17 I HEREBY CERTIFY, That I attended deceased from No Record, 19..., to ..., 19...,

that I last saw h.. alive on ..., 19...,

and that death occurred, on the date stated above, at 4.20 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) ...yrs. ...mos. 1 ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. C. Warnes, M. D.

April 6, 1927 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Date of Burial April 8 1927

20 UNDERTAKER Chas. E. Turner Sons ADDRESS 1133 Valley St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 20971

REGISTERED NO. E 20971

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard Norris

(a) RESIDENCE NO. Towson - Md St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | Col | Baby |

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1-5-1926

| 7 AGE Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|
| 13 hrs | 3 | 1 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md

PARENTS

10 NAME OF FATHER Thomas Norris

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md -

12 MAIDEN NAME OF MOTHER Grace Johnson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 19

By Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

April 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 7 1927, 19 to April 6 19 27,

that I last saw him alive on April 5 19 27,

and that death occurred, on the date stated above, at 6 m.

The CAUSE OF DEATH* was as follows:

Pneumococcus meningitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Pneumonia - Pyelitis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Laboratory tests

(Signed) J. H. Bruce, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pleasant Rest, Towson Md Date of Burial 4/8/1927

20 UNDERTAKER Mrs. Geo. H. Holland ADDRESS 1631 Druid Hill Ave

APR 8 1927 C. HAMPSON JONES, M. D.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 20972

129 E 20972

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1108 E. Pratt St. WARD) 5

2-FULL NAME Moses Grossfeld

(a) RESIDENCE No. 1108 E Pratt St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? 7 yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | white | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Grossfeld

6 DATE OF BIRTH (month, day, and year) [illegible]

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 63 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) old age

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Jacob Grossfeld

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Einhorn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mrs. Rubenstein

(Address) 224 S. Eden

APR- 7 1927

15 Filed [illegible] HAMILTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7 19 27

17 I HEREBY CERTIFY, That I attended deceased from [illegible] 19 [illegible] to April 5 19 27

that I last saw h alive on 19

and that death occurred, on the date stated above, at 10.30 a m

The CAUSE OF DEATH was as follows: *

Hemiplegia

arteriosclerosis

nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart failure.

(duration) 2 yrs mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Nathan Jolly M. D.

19 (Address) 1827 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt Carmel

DATE OF BURIAL 4/7 19 27

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of Certificates.

Spec. 7-17-26—A Co.—200 Bks.

20973

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

1-001

E 20973

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1726 Marshall St. 1331 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John A Koontz

(a) RESIDENCE NO. 1726 Marshall St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married. |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary T Koontz

6 DATE OF BIRTH (month, day, and year) April 19 1875

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min.. |
|---|---|---|---|---|
| | 51 | 11 | 23 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland.

(State or country)

PARENTS

10 NAME OF FATHER Frank Koontz

11 BIRTHPLACE OF FATHER (City or town) Maryland

(State or country)

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) Maryland

(State or country)

14 Informant Mary T Koontz

(address) 1726 Marshall St

15 Filed APR - 7 1927, 19 C. HAMPSON JONES, M. D.

Registrar

Per R.H.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-4th 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 2, 1927, to Mar 4, 1927

that I last saw h alive on Mar 4, 1927

and that death occurred, on the date stated above, at 10 15P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R.H. Campbell M. D.

Apr 6, 1927 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — Date of Burial 4-7 1927

20 UNDERTAKER E B Harle — ADDRESS 115 E Pratt St.

IMPORTANT, etc. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Pippin ✓

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20974 — 109-002 — E 20974

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Maryland General Hospital

CITY OF BALTIMORE: (No. ) ST. 11-24 (WARD)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Emma Pippin

(a) RESIDENCE NO. Chester town Md. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female — 4 COLOR OR RACE: White — 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ~~April 6th~~ 1864

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| 63 | 62 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John W. Brownley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Eliz. Auld

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Husband (Address)

Filed APR 7 1927 C. HAMPSON JONES, M. D. Registrar

By RK

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1927

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1927, to April 6, 1927, that I last saw her alive on April 6, 1927, and that death occurred, on the date stated above, at 11:20 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Throat

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Oedema of Larynx

(duration) yrs. mos. 4½ days

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 4-6-27 Tracheotomy.

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno A Young Jr. M. D.

4/9/27 (Address) 11 E Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Chestertown, Md. — DATE OF BURIAL 4/11 1927

20 UNDERTAKER E. J. Fanning Nov-1938 — ADDRESS E. Lafayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20975

# CERTIFICATE OF DEATH.

E 20975

REGISTERED NO. 90

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St. 23-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Hill

(a) RESIDENCE NO. 31 W Cross St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Negro | ? |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1876

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 51 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Military

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Angeline —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant BALTIMORE CITY HOSPITALS

(Address) [redacted] Records

15 Filed [illegible] 1927 C. HAMPSON JONES, M. D. Registrar

1936 Nov

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 1927

17

I HEREBY CERTIFY, That I attended deceased from September 27 1926, to April 5, 1927, that I last saw h[illegible] alive on April 4, 1927, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. mos. ? ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? yes Date of

Was there an autopsy? no

What test confirmed diagnosis? general & laboratory

(Signed) R Hooper Lovell, M. D.

(Address) Apl 6 1927 BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 19

UNIVERSITY OF MARYLAND

20 UNDERTAKER ADDRESS

Commissioner Health APR 7 1927

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

E 20976 HEALTH DEPARTMENT—CITY OF BALTIMORE E 20976

# CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2543 Penna ave ST. 13-69 (WARD) 90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Andrew Depkens

(a) RESIDENCE NO. 2543 Penna ave ST., 20 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| male | white | Widower |

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Late Ellen M. Mahon Depkens

6 DATE OF BIRTH (month, day, and year) Unknown 1854

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 72 73 | — | — | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Labor
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Depkens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Margaret Snyder
(Address) 1820 Jackson St

15 Filed 1927 C. HAMPSON JONES, M. D., Registrar
By

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/6/ 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)

4/6, 1927 (Address) 1632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Cedar Hill Cem. | 4/8/ 1927 |
| 20 UNDERTAKER John F. Cowan & Son | ADDRESS |
| Per F. J. Cowan | 901 Hollins |

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of this item is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 20977

161-00 E 20977 L

REGISTERED NO. _____

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 15-21 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Baby (Girl) Freyman

(a) RESIDENCE NO. 1807 Wellwood Ave St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word)

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4/7/27

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..hrs. or 15 min. |
|---|---|---|---|---|
| | | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ...0d

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md

(State or country)

PARENTS

10 NAME OF FATHER George Freyman

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Balto, Md

12 MAIDEN NAME OF MOTHER Lillian Shelton

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Somerset Co. Md.

14 Informant ...
(Address)

15 Filed APR 7 1927 C. HAMPSON JONES, M. D. Registrar

By _____

123

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

4-7-27

17

I HEREBY CERTIFY, That I attended deceased from 4-7, 1927, to 4-7, 1927, that I last saw her alive on 4-7, 1927, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY _____
(Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted

If not at place of death? _____

Did an operation precede death? ...Date of...

Was there an autopsy? No

What test confirmed diagnosis? Clinical test

(Signed) Harry Weintraub, M. D.

. 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

JOHNS HOPKINS HOSPITAL

20 UNDERTAKER — ADDRESS

Commissioner Health — APR 7 - 1927

R 7 1927

Per ...

...ated EXACTLY. PHYSICIANS should be careful... State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

138 E 20978

E 20978

## CERTIFICATE OF DEATH

1-PLACE OF DEATH Gonorrhea - Dem. Hosp. 26-37

City of BALTIMORE: (No. _____ St. _____ Ward)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Elizabeth Rosel

(a) RESIDENCE NO. 1401 S. 8th St. — St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Michael P. Rosel

6 DATE OF BIRTH (month, day, and year) June 13, 1886

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 40 years | 9 | 21 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany

(State or country)

PARENTS

10 NAME OF FATHER Herman Ires

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Michael Rosel

(Address) 1401 S. 8th St

15 Filed 4-7 1927 C. J. WILSON JONES, M. D.

For BRN Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

4-4-1927

17

I HEREBY CERTIFY, That I attended deceased from 3-27, 1927, to 4-4, 1927, that I last saw her alive on 4-4, 1927, and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Acute myocardial failure (Gray)

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No. Date of 4-2-27

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. Travis, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem. Date of Burial April 8th 1927

20 UNDERTAKER Lilly & Filer ADDRESS 403 S. Wolfe St.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20979

## CERTIFICATE OF DEATH.

170 E 20979

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital Ward 12-59)

2-FULL NAME Ned Liberles Jr.

(a) RESIDENCE NO. Monterey Apts. St. D. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jany. 16 1904

7 AGE — Years: 23 — Months: 2 — Days: 20 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Financier

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Self.

9 BIRTHPLACE (city or town): Balto.

(State or country): Md.

PARENTS

10 NAME OF FATHER: Ned Liberles

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Rosa Rosenfeld

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Balto. Md.

14 Informant: Miss Lucille Liberles

(Address): Monterey Apts

15 Filed ..... 19 C. HAMPSON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/6/ 1927.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Gunshot Wound of brain

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart failure

(duration) yrs. mos. ds.

4/8/27 (Signed) A. Gundry M. D.

(Coroner)

4/8, 1927 (Address) 1039 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Har Sinai Cem. Date of Burial: 4/8/ 1927.

20 UNDERTAKER: David Sondheim ADDRESS: 1120 W Mt Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. This certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

APR 7 1927

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20980

## CERTIFICATE OF DEATH

129 E 20980

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Esplanade Apts 413-59 St.) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Etta Salabes

(a) RESIDENCE NO. Esplanade Apts. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jody Salabes

6 DATE OF BIRTH (month, day, and year) Sept. 6, 1850.

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min. |
|---|---|---|---|---|
| | 76 | 7 | 0 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Solomon Lewyt

11 BIRTHPLACE OF FATHER (City or town) (State or country) Holland

12 MAIDEN NAME OF MOTHER Sarah Leon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Holland

14 Informant Mr. S. Salabes

(Address) Esplanade Apts

15 Filed APR 7 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/6/1927

17 I HEREBY CERTIFY, That I attended deceased from [illegible], 19[illegible], to April 6, 1927, that I last saw h[illegible] alive on April 6, 1927, and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis & Chr Nephritis (duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Julian Friedenwald M. D.

, 19 (Address) 1013 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Balto. Hebrew Cem. | 4/8/1927 |
| 20 UNDERTAKER David Sondheim | ADDRESS 1120 W. Lexington Royal Ave |

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20981

## CERTIFICATE OF DEATH.

E 20981

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 7-9 Ward)

2-FULL NAME George Edwin Joseph

(a) RESIDENCE NO. Douglasston Long Island-N.Y. Ward Brady-5
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Mabelle Joseph

6 DATE OF BIRTH (month, day, and year) Jan-31-1873

| 7 AGE Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|
| 54 | 2 | 6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) N. Y.
(State or country)

PARENTS

10 NAME OF FATHER N. Joseph

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Rosa Jackson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) JOHNS HOPKINS HOSPITAL ?

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed APR 7 1927 C. HAMPSON JONES, M. D. Registrar
Per RKR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7-1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 26 1927, to April 7 1927, that I last saw h alive on April 7 1927, and that death occurred, on the date stated above, at 10 35 9 m.

The CAUSE OF DEATH* was as follows:

Papillary infiltrating carcinoma urinary bladder

approximate (?) (duration) 2 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Pyonephrosis. Uremia

Several weeks (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) Raymond F. Spruit M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New York City Date of Burial April 7 19

20 UNDERTAKER H. W. Jenkins & Sons Co ADDRESS McCulloh & Eutaw

NOTE.—WHITE PAPER; BLUE CARBON AND PINK PAPER MUST BE EXACTLY UNDER THIS. PHYSICIANS should state CAUSES OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

R-

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20982

## CERTIFICATE OF DEATH.

90 E 20982

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1206 Harford Ave St. 10-14 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James H. McClerking

(a) RESIDENCE NO. 1206 Harford Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Widower |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Lillian McClerking

6 DATE OF BIRTH (month, day, and year) June 29/1879

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 47 | 9 | 7 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER James H. McClerking

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto., Md.

14 Informant James H. McClerking 3rd

(Address) 1206 Harford Ave

15 Filed C. HAMPSON JONES, M. D. Registrar

4-7 1927

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 6/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Chr Myocarditis

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) J. H. Ritter M. D.

(Coroner)

4/7/27 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Country Date of Burial April/2 1927

20 UNDERTAKER George F. Ruth ADDRESS 735 Harford Ave.

R. R.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 20983

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20983

## CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1608 Clifton Place ST. 5-21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Shomm

(a) RESIDENCE No. 1608 Clifton Place ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4yrs mos ds. How long in U. S., if of foreign birth? yrs mos ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, ~~or Divorced~~, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rose B. Shomm

6 DATE OF BIRTH (month, day, and year): March 2/68

7 AGE: Years 59. Months 1 Days 3. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cigar

(b) General nature of industry, business, or establishment in which employed (or employer): Mfg.

(c) Name of employer: Schaffer Co

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Christian Shomm

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Fuhrmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant (Address): Mrs Rose B. Shomm 1601 Clifton Place.

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 5 1927.

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1927. to April 5, 1927. that I last saw him alive on April 4, 1927 and that death occurred, on the date stated above, at 8.25 P. M.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) 2 yrs mos ds

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine, Blood Pressure

(Signed) E. L. Pennington, M. D.

4.6. 1927 (Address) 514 Druid Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery. DATE OF BURIAL: April 8 1927

20 UNDERTAKER: George L. Ruth ADDRESS: 1735 Harford Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

R-7 1927

Spec.—1-12-23—M&T—500 Blks.

E 20984

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20984

## CERTIFICATE OF DEATH.

47

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 4510 Lorretta Ave. 27-41 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida M. Schmidt

(a) RESIDENCE No. 4510 Lorretta Ave. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Adam R Schmidt

6 DATE OF BIRTH (month, day, and year): 10/18 1870

7 AGE: Years 56 | Months 5 | Days 18 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Co Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Co Md

14 Informant: Mr Chagle Spittle

(Address): 4510 Lorretta Ave

15 [illegible] 7 1927 19[illegible] C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr. 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 12 1927 to Apr. 6 1927.

that I last saw h[illegible] alive on Apr. 6. 1927

and that death occurred, on the date stated above, at [illegible]

The CAUSE OF DEATH* was as follows: Exhaustion & Toxaemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Breast

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. Smith, M. D.

(Address) 4 W. Mt. Hope Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Emmanuel Cemetery

DATE OF BURIAL: 4/9 1927

20 UNDERTAKER: George J Ruth

ADDRESS: 1730 Harford Ave

INFORM should be carefully supplied. Age should be stated EXACTLY. Fractions of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20985 × 57 E 20985

## CERTIFICATE OF DEATH

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. University Hospital St. 4-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edwd B Lankford

(a) RESIDENCE NO. Pocomoke City St. Md Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| m | W | M |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Susan J (nee Morris)

6 DATE OF BIRTH (month, day, and year) June 17. 1863

| 7 AGE | Years | Months | Days |
|---|---|---|---|
| | 63 | 9 | 21 |

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Lumber Business

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Arthur N Lankford

11 BIRTHPLACE OF FATHER (City or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Ann Cluff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs Edward B Lankford

(Address) Pocomoke City Md

15 Filed APR - 8 1927 19 C. HAMPSON JONES Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 15 1927 to Apr 7 1927

that I last saw him alive on Apr 7 1927

and that death occurred, on the date stated above, at 12.15 P m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

Generalized Arteriosclerosis

Perforated ulcer right foot (duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Gas gangrene. (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? Yes Date of Apr. 4, 1927

Was there an autopsy? Right leg amputated

What test confirmed diagnosis?

(Signed) E. P. Miller, M. D.

19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pocomoke City Md — Date of Burial April 10 27

20 UNDERTAKER Harry H Nittle — ADDRESS 1531 Fawn St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 20986

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20986

## CERTIFICATE OF DEATH.

74-062

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 118 S Gilmor St. (ST.) 19-28 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida J. Siemers.

(a) RESIDENCE NO. 118 S Gilmor St. (ST.) (WARD)

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry F. Siemers

6 DATE OF BIRTH (month, day, and year) Aug. 27, 1863

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 63 | 7 | 9 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington, D. C.

PARENTS

10 NAME OF FATHER Thomas Russell,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Lillie Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washinton D. C.

14 Informant Mr. Henry F. Siemers.

(Address) 118 S Gilmor St

15 Filed APR 8 1927 C. HAMILTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 1927

17

I HEREBY CERTIFY, That I attended deceased from Mar. 30, 1927, to April 5, 1927.

that I last saw her alive on April 5, 1927

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac Decompensation

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Cerebral embolus (?)

(duration) yrs. mos. 4 hrs.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) Anthony V. Bucheuer M. D.

, 19 (Address) 37 S. Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Apr. 8 1927

20 UNDERTAKER Harry H. Witzke

ADDRESS 531 W. Lombard St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS STATEMENT mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20987

## CERTIFICATE OF DEATH.

E 20987

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St. 16 Ward)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachel Jackson

(a) RESIDENCE NO. 805 N. Stricker St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1871

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 56 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore City (State or country) Maryland

PARENTS

10 NAME OF FATHER William Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Records

15 Filed APR 8 1927, 19

C. HAMPSON JONES, M. D. Registrar

Per [redacted]

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 1927

17

I HEREBY CERTIFY, That I attended deceased from February 1 1927, to April 5, 1927, that I last saw h.e.s. alive on April 5, 1927, and that death occurred, on the date stated above, at 9 A.M. p.m.

The CAUSE OF DEATH* was as follows:

Myocardial hypertrophy & Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) yrs. mos. 21 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis? General & Laboratory

(Signed) R. Hooper Lamb M.D.

April 7 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. Date of Burial April 8th 1927

20 UNDERTAKER Daniel Easton ADDRESS 916 Pine

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20988

## CERTIFICATE OF DEATH.

100-999 ✓ E 20988

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 106 S Amity ST. 18-29 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edmund E. Arrington

(Residence in Baltimore: No. 106 S. Amity St.; yrs., mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

| 3-SEX. | 4-COLOR OR RACE. | 5-SINGLE, MARRIED, WIDOWED, or DIVORCED, (*Write* the word.) |
|---|---|---|
| Male | White | — |

6-DATE OF BIRTH, Apl 6 1927, 1927
(Month) (Day) (Year)
2

7-AGE, ....yrs. 2 mos.....ds. If LESS than 1 day, ....hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Chas Arrington

11-BIRTHPLACE OF FATHER (State or Country), Balt.

12-MAIDEN NAME OF MOTHER Nettie Gay

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Dugan.

(Address) 106 S Amity

15-

Filed....., 191.... C. HAMPSON JONES, M. D. Registrar.

APR - 8 1927

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 6, 1927.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 1, 1927, to April 6 1927, that I saw him alive on April 6. 1927, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Acute Broncho-Pneumonia

(Duration) ...yrs. ...mos. 5 ds.

CONTRIBUTORY (Secondary) none

(Duration) ...yrs. ...mos. ...ds.

(Signed) J Thas Worden, M. D.

4/7/27, 191... (Address) 858 W Lombard

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

| 19-PLACE OF BURIAL OR REMOVAL, | DATE OF BURIAL, |
|---|---|
| W Lawn | April 8., 1927 |
| 20-UNDERTAKER | ADDRESS |
| John H Fuldner | 20 W Lombard |

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

E 20989 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 20989
Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3139 Cedar ave St., 13-51 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Azar

(Residence in Baltimore: No. 3139 Cedar ave St.; yrs. 64. 20 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed, or Divorced.~~ (Write the word.) Widow

6-DATE OF BIRTH. Aug 22 1862
(Month) (Day) (Year)

7-AGE. 74 yrs. 7 mos. 15 ds.

If LESS than 1 day, ....hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Canada

PARENTS.

10-NAME OF FATHER. Mitchel Hebert

11-BIRTHPLACE OF FATHER. (State or Country) Unknown

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER. (State or Country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert J Azar

(Address) 3139 Cedar ave

15-

Filed ..... 192.. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. April 7 1927
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of Heart

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Wm. Morrison M. D.
(Coroner.)

4/8 1927 (Address) 7632 Roland ave

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. St Mary's Hampton DATE OF BURIAL. Apl 9 1927

20-UNDERTAKER. Emerson Stephen Chestnut ADDRESS 3617

N B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

APR 8 1927 C. HARRISON JONES, M. D.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20990

## CERTIFICATE OF DEATH.

E 20990

1-PLACE OF DEATH West Baltimore General Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Fayette and Dukeland St. 16 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johanna Hulse

(a) RESIDENCE NO. Odenton, Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. 5 mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX F. 4 COLOR OR RACE White 5 ~~Single, Married, Widowed~~ or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julian Hulse

6 DATE OF BIRTH (month, day, and year) Feb 7/1879

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 48. | 1 | 29 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Julian Hulse (Address) Odenton Md.

15 Filed APR. 8, 1927 C. HAMPTON TALBOTT, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/6 1927

17 I HEREBY CERTIFY, That I attended deceased from 11/3, 1926, to 4/6, 1927, that I last saw h[illegible] alive on 4/6, 1927 and that death occurred, on the date stated above, at 10:30 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Benjamin Miller, M. D.

, 19 (Address) W. B. & A.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Park Cem

DATE OF BURIAL April 9 1927

UNDERTAKER Lemmon & Son 3617 Eastern Ave.

ADDRESS

IMPORTANT. AGE should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20991

## CERTIFICATE OF DEATH.

10-003

13-52

E 20991

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Forrest Richard Williams

(a) RESIDENCE NO. 3517 Hickory Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. 11 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | white | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 17, 1918

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 8 | 11 | 21 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Frank Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Hattie E. Shaffer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Frank Williams

(Address) 3517 Hickory Ave

15 Filed ..... 19 .....

Per .....

Registrar

APR - 8 1927 HAMPSON JONES, M. D.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7 1927

17

I HEREBY CERTIFY, That I attended deceased from April 6, 1927, to April 7, 1927, that I last saw him alive on April 7, 1927 and that death occurred, on the date stated above, at 3 25 a m.

The CAUSE OF DEATH* was as follows:

Nasal, Tonsillar & Pharyngeal Diphtheria

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Pos. Autopsy

(Signed) Myron G. Tull, M. D.

4/7, 1927 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge — DATE OF BURIAL Apl 8 1927

20 UNDERTAKER Ehrenwerth Son — ADDRESS 3417 Chestnut Ave

N. B. WRITE plainly with pen and ink. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

20992

## CERTIFICATE OF DEATH

160 ✓ E 20992

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 4322 Bucks Lane St. 28-63 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mildred E. Brunson.

(a) RESIDENCE NO. 4322 Bucks Lane St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 8/1926.

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..hrs. or ..min.. |
|---|---|---|---|---|
| | | 3 | 29 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) md.

PARENTS

10 NAME OF FATHER Walter S. Brunson

11 BIRTHPLACE OF FATHER (City or town) Pa.
(State or country)

12 MAIDEN NAME OF MOTHER Lucia Proctor

13 BIRTHPLACE OF MOTHER (city or town) md.
(State or country)

14 Informant Walter S. Brunson
(Address) 4322 Bucks Lane

Filed APR-8 1927 H. MACKALL JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7, 1927

17 I HEREBY CERTIFY, That I attended deceased from March 26, 1927, to April 7, 1927, that I last saw h[illegible] aliva on April 6. 1927, and that death occurred, on the data stated above, at 2.15a m.

The CAUSE OF DEATH* was as fellows:

Marasmus

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Inanition

(duration) yrs. mos. 10 ds.

18 Where was disease contracted

If not at place of death? ✓

Did an operation precede death? No Data of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Methods

(Signed) George L. Shannon, M. D.

4/7. 1927 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

Date of Burial 4/8 1927

20 UNDERTAKER Chenowith Sons.

ADDRESS 3615 Chestnut Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 20993

## CERTIFICATE OF DEATH

E 20993

REGISTERED NO.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2609 Bernard St. 12-51 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ralph E Shalk

(a) RESIDENCE NO. 2609 Bernard St. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 8, 1926.

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|---|
| | | 11 | 29 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) md.

(State or country)

PARENTS

10 NAME OF FATHER Wm R. Shalk.

11 BIRTHPLACE OF FATHER (City or town) md

(State or country)

12 MAIDEN NAME OF MOTHER Mary E. Webb.

13 BIRTHPLACE OF MOTHER (city or town) md

(State or country)

14 Informant Wm R. Shalk.

(Address) 2609 Bernard St

15 Filed APR-8 1927 19 H. M. [illegible] Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7, 1927

17 I HEREBY CERTIFY, That I attended deceased from April 4, 1927, to April 7, 1927,

that I last saw h— alive on April 7, 1927,

and that death occurred, on the date stated above, at 5:a m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) 3 yrs. mos. da.

18 Where was disease contracted —

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature] M. D.

April 7, 1927 (Address) 112 W. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Marys Hampden

Date of Burial 4/9 19 27

20 UNDERTAKER Chenowethsdon.

ADDRESS 3615 Eastern Ave

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20994

## CERTIFICATE OF DEATH.

90 E 20994

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St. 10-14 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Wallace

(a) RESIDENCE NO. 1036 E. Monument St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Negro | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) '85 2

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 45 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Va

PARENTS

10 NAME OF FATHER Henry Wallace

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Mary Dearter

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant BALTIMORE CITY HOSPITALS

(Address) [redacted]

15 Filed APR 8 1927 19 [illegible] Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 1927

17 I HEREBY CERTIFY, That I attended deceased from April 4 1927, to April 5 1927, that I last saw him alive on April 5 1927, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency

Mitral Insufficiency

(duration) yrs. ? mos. ds.

CONTRIBUTORY Myocardial failure

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) R. Hooper Lamb, M. D.

April 6 1927 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: ashury cemetery Date of Burial: april 9 1927

20 UNDERTAKER: Edward Bryan ADDRESS: 691 orleans st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20995

## CERTIFICATE OF DEATH.

E 20995

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1516 E. Fayette St. ST., 6-9 WARD)

2-FULL NAME Leonard Jones

(a) RESIDENCE No. 1516 E. Fayette St. ST., WARD 9 C.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WHITE PAPER, WITH ONE CARBON, USED FOR THIS CERTIFICATE. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colord | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1910

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 17 | | | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C

PARENTS

10 NAME OF FATHER Sidney Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) U. S. A

12 MAIDEN NAME OF MOTHER Martha Pottila

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C

14 Informant Sidney Jones
(Address) 1516 E. Fayette St.

15 Filed APR 8 1927 19 H. HAMILTON JONES, M. D. Registrar
By K/K

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 1927

17 I HEREBY CERTIFY, That I attended deceased from March 30, 1927. to April 5. 1927.
that I last saw him alive on April 5 — 1927.
and that death occurred, on the date stated above, at 8:30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Myocarditis (duration) yrs. mos. 4 ds.

18 Where was disease contracted? if not at place of death? .....
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical & Blood Ex.
(Signed) J. M. Miller M. D.
4/6, 1927 (Address) 1613 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery — DATE OF BURIAL April 1927

20 UNDERTAKER Edward Bryan — ADDRESS 651 Orleans St

Spec.—12-9-25—A Co.—200 Bks.

E 20996

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 20996

REGISTERED NO.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St. 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Bell Young

(a) RESIDENCE NO. 216 Jasper St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Negro | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1876

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 51 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER George Bell Young

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliza Jane

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant

(Address) Records

15 Filed APR 8 1927 C. HAMPSON JONES, M. D. Registrar

Per RM

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4 1927

17

I HEREBY CERTIFY, That I attended deceased from March 16, 1927, to April 4, 1927, that I last saw him alive on April 4, 1927, and that death occurred, on the date stated above, at 11 10 P m.

The CAUSE OF DEATH* was as follows:

Cortex Encephalomyelitis

Relative Mitral Insufficiency

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) yrs. mos. 4 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? general & laboratory

(Signed) R Hooper Smith, M. D.

April 7 1927 Address [redacted]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury cemetery Date of Burial April 8 1927

20 UNDERTAKER Edward Bryan ADDRESS 1691 Orleans st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20997

## CERTIFICATE OF DEATH

E 20997

REGISTERED NO.

1-PLACE OF DEATH University Hospital

City of BALTIMORE: (No. 430 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George C Sigerman

(a) RESIDENCE NO. Sykesville St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. mos. 1 ds. How long in U. S. if of foreign birth? — yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 ~~Single~~, ~~Married~~, ~~Widowed~~, or Divorced. (write the word): D.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Divorced

6 DATE OF BIRTH (month, day, and year): Oct. 1871

7 AGE: Years 55 Months 6 Days — IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Thomas Sigerman

11 BIRTHPLACE OF FATHER (City or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary E Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mary E Leist

(Address): Sykesville, Md

15 Filed APR - 8 1927, 19 H. MASON JONES, M. D. Registrar

By RA

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/6/27 19

17 I HEREBY CERTIFY, That I attended deceased from 4/4/27, 19 ... to 4/6/27, 19 ...

that I last saw h[illegible] alive on 4/6/27, 19 ...

and that death occurred, on the date stated above, at 8:30 p. m.

The CAUSE OF DEATH* was as follows:

Central Hemorrhage right

(Cerebral Hemiplegia)

(duration) ... yrs. ... mos. 18 ds.

CONTRIBUTORY (Secondary) Terminal Pneumonia

(duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. S. Winstead, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Mount — Date of Burial: April 8 19 27

20 UNDERTAKER: John O. Mitchell — ADDRESS: 1915 Eutaw Place

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 20998

## CERTIFICATE OF DEATH

E 20998

REGISTERED NO.

Mennige 329 E North Ave re 7:30 — 11-001 9-46

1-PLACE OF DEATH

City of BALTIMORE: (No. 3003 Ellerslie Ave St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Marie Clark

(a) RESIDENCE NO. 3003 Ellerslie St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. da. How long in U. S. if of foreign birth? yrs. mos. da.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 30, 1921

| 7 AGE | Years | Months | Days | IF LESS than 1 day hrs. or min.. |
|---|---|---|---|---|
| | 6 | | 7 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Harry F. Clark

11 BIRTHPLACE OF FATHER (City or town) N. Y.

(State or country)

12 MAIDEN NAME OF MOTHER Ena P. Smith

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country)

14 Informant Harry F. Clark

(Address) 3003 Ellerslie Ave

15 Filed APR - 6 1927 Registrar C. HAMILTON JONES, M. D.

Per R.K.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Mar 31st 1927 to Apr 7th 1927

that I last saw her alive on Apr 7th 1927

and that death occurred, on the date stated above, at 9:30 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 5 da.

CONTRIBUTORY (Secondary) La Grippe

(duration) yrs. mos. 14 da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A C Manning M. D.

4-7-1927 (Address) 323 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Date of Burial Apr 9 1927

20 UNDERTAKER ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 20999

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 20999
REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Maryland Gen. Hosp. 11-24 162

CITY OF BALTIMORE: (No. ST., WARD)

2-FULL NAME Baby Simons

(a) RESIDENCE NO. 74 Kingsley rd Dundalk WARD
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 7, 1927

7 AGE — Years — Months — Days: 2 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: pre-school age

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore md.
(State or country)

PARENTS

10 NAME OF FATHER Frank Simons

11 BIRTHPLACE OF FATHER (city or town) Brooke W. Va.
(State or country)

12 MAIDEN NAME OF MOTHER Mabel White

13 BIRTHPLACE OF MOTHER (city or town) W. Va
(State or country)

14 Informant Mabel Hutchinson
(Address) 74 Kingsley Road

15 Filed APR 8 1927 C. HAMPSON JONES, M. D. By RR. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7 1927

17 I HEREBY CERTIFY, That I attended deceased from April 4, 1927, to April 7, 1927,
that I last saw her alive on April 6, 1927,
and that death occurred, on the date stated above, at 12.15 A. m.

The CAUSE OF DEATH* was as follows:

Atelectasis
Non-development
and child female of twin

(duration) yrs. 1 mos ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Jas A Simons Jr M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Hampden — DATE OF BURIAL 4/8 1927

20 UNDERTAKER Wm Cook — ADDRESS 502 E Wms

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

54

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 21000 — REGISTERED NO. 37-00 E 21,000

1-PLACE OF DEATH

City of BALTIMORE: (No. 1427 Gough St. 3-5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Angelo Louis

(a) RESIDENCE NO. 1427 Gough St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W. | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Eva M Louis

6 DATE OF BIRTH (month, day, and year): Oct 12, 1896

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|---|
| | 30 | 5 | 25 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: B&O RR

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Antonio Louis

11 BIRTHPLACE OF FATHER (City or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Richmore

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Eva Louis

(Address): 1427 Gough St

16 Filed APR. 8 1927, 19 ..., Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 4 1927

17 I HEREBY CERTIFY, That I attended deceased from January 15, 1927, to March 25, 1927

that I last saw h[illegible] alive on March 25, 1927

and that death occurred, on the date stated above, at 1:30 p. m.

The CAUSE OF DEATH* was as follows:

General Arteriosclerosis

(duration) 3 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary): Myocardial insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M H Offutt M. D.

4-5, 1927 (Address) 1515 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore — Date of Burial: Apr 9 1927

20 UNDERTAKER: J. Cook — ADDRESS: 507 E Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

9 E 21001 ✓ 16-002 E 21001

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Leitch

(a) RESIDENCE NO. Summit Ave St. Ward Carey-wick

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 22. 1927

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | | 9 mos. | (19) | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ods

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md

(State or country) Balt

PARENTS

10 NAME OF FATHER John Leitch

11 BIRTHPLACE OF FATHER (city or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Cecilia Speer

13 BIRTHPLACE OF MOTHER (city or town) Germany

(State or country)

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 .....

Per ..... Registrar

APR 8 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr 4 1927, to Apr 7, 1927, that I last saw h[illegible] alive on Apr 7, 1927, and that death occurred, on the date stated above, at 8:50 a. m.

The CAUSE OF DEATH* was as follows:

Intracranial Hemorrhage

Cause undetermined

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) [illegible]athman, M. D.

, 19 (Address) JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Glen Cathedral Date of Burial Apr 9 1927

20 UNDERTAKER Wm Cook ADDRESS 502 E Balto St

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21002

## CERTIFICATE OF DEATH.

90

E 21002

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 222 N. Gilmor ST. 14-27 WARD)

2-FULL NAME Ephriam Ennis

(a) RESIDENCE NO. 222 N. Gilmor St ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred ~~mos~~ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 12, 1900

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 27 | 1 | 23 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cementer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Prince George Co Md.

PARENTS

10 NAME OF FATHER John W. Ennis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co Md

12 MAIDEN NAME OF MOTHER Cornelia Mitchell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Anne Arundel Co Md

14 Informant John W. Ennis

(Address) 1828 Mullin St.

15 Filed APR. 8 1927 C. HAMPSON JONES, M. D. Registrar

By R R

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-5 1927

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1926, to Apr 5, 1927,

that I last saw him alive on Apr 3, 1927

and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation. Cardiac decompensation

about (duration) 10 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Inflam. Rheumatism

Unknown (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Chas. C. Conser, M. D.

4/5, 1927 (Address) 1101 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dorsey Balto DATE OF BURIAL 4-8 1927

20 UNDERTAKER George T. A. Gibson ADDRESS 1735 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21003

## CERTIFICATE OF DEATH.

57 E 21003

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1700 Westwood Ave (St.) 15-21 (Ward)

2-FULL NAME Frank J. Strohminger

(a) RESIDENCE NO. 1700 Westwood Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Norma Gertrude Strohminger

6 DATE OF BIRTH (month, day, and year) July 19th 1873

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 53 | 8 | 19 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clothing Trimmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Schloss Bros. & Bacho

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apl 7 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 18, 1926, to Apl 7, 1927, that I last saw him alive on Apl 7, 1927, and that death occurred, on the date stated above, at 810 A m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

about 2 yrs. mos ds.

(duration)

CONTRIBUTORY (Secondary) Pleurisy

(duration) — yrs. — mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) O. H. Duvall, M. D.

4/7, 1927 (Address) 1817 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

14 Informant (Address) Norma Gertrude Strohminger 1700 Westwood Ave

15 Filed APR 8 1927, 19 C. HAMILTON JONES, M. D. Registrar

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL 4/9/1927

20 UNDERTAKER Geo. Weber & Son

ADDRESS 2503 Ed. Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21004

## CERTIFICATE OF DEATH.

E 21004

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 129 E. Lees St. 24 WARD)

2-FULL NAME Ann Gleason

(a) RESIDENCE. No. 129 E Lees St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Fem | White | Mrg d |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug. 11 1926

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 8 | 7 | 25 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Jacksonville Duval Co Fla

PARENTS

10 NAME OF FATHER Patrick Gleason

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kilkenny Ireland

12 MAIDEN NAME OF MOTHER Bridget Lees

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Patrick Gleason
(Address) 129 E Lees St

15 Filed APR. 8 1927 H. M. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1927

17 I HEREBY CERTIFY, That I attended deceased from March 27 1927 to April 6 1927.

that I last saw her alive on April 6 1927.

and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. — mos. 14 hrs.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. Bischelle M. D.

4/7 1927 (Address) 1279 Hillman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dudley Hill Cemetery DATE OF BURIAL: Apr. 9 1927

20 UNDERTAKER: George L. Schwab ADDRESS: 1101 Eutaw Pl

HAMILTON JONES, M. D.

---

INSTRUCTIONS.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21005

## CERTIFICATE OF DEATH.

100-001

E 21005

REGISTERED NO.

1-PLACE OF DEATH Balto City Hospts

City of BALTIMORE: (No. Balto Ind St Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John G. Tedderman

(a) RESIDENCE No. 1337 S. Clinton St Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 73; Months; Days; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer): None
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country): Ireland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Unknown

14 Informant: Balto City Hospts
(Address): Balto Md

15 Filed ..... 19 .....
C. HAMPTON JONES, M. D.
Registrar

APR - 8 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 5 27

17 I HEREBY CERTIFY, That I attended deceased from 3-17, 1927 to 4-5, 1927
that I last saw him alive on 4-4, 1927,
and that death occurred, on the date stated above, at 3.01 A. m.

The CAUSE OF DEATH* was as follows:
Terminal Bronchopneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Senile Psychosis w/ Deterioration

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Henry H. Tedderman M. D.

4/5, 1927 (Address) 1337 S. Clinton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem. Date of Burial: April 9 1927

20 UNDERTAKER: Lilly and Zeller ADDRESS 403 S. Wolfe St

G. R.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

20 E 19
21006

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

X 100-001
E 21006

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Nowicki

(a) RESIDENCE NO. Fernem Hall Rd — St. Grey Mare Pk. Sharon Pl.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1875

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| 58 | 52 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Poland -
(State or country)

PARENTS

10 NAME OF FATHER Jacob Nowicki

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) —
(State or country)

14 Informant Records -
(Address) JOHNS HOPKINS HOSPITAL

15 Filed APR - 8 1927 19 Per C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 7 1927

17

I HEREBY CERTIFY, That I attended deceased from Mar 13, 1927, to Apr 7, 1927, that I last saw him alive on Apr 7, 1927, and that death occurred, on the date stated above, at 9 P— m.

The CAUSE OF DEATH* was as follows:

Cellulitis rt. leg

(duration) yrs. mos. 29 ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) Milton Sherry, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Holy Rary Cem April 9 1927

20 UNDERTAKER — ADDRESS

John M Weber 1803 Bank St

N B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 21007

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21007

## CERTIFICATE OF DEATH.

7 118-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp. ST., 9-1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Bessie Waltman

(a) RESIDENCE NO. Joppa, ST., ..... WARD 2nd.
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 2 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 10-1875

| 7 AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 52 | 6 | 26 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER George K. King

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Catherine A McManus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, Md.

14 Informant Mary R. Smith
(Address) 211 W. Lafayette St.

15 Filed APR-8 1927 C. HARRISON JONES, M. D. Registrar

Per ...

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/8 1927

17

I HEREBY CERTIFY, That I attended deceased from 4/6, 1927, to 4/8, 1927.

that I last saw her alive on 4/8, 1927.

and that death occurred, on the date stated above, at 4 25 A m.

The CAUSE OF DEATH* was as follows:

Strangulated ventral hernia with Intestinal obstruction

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Cardiac Dilitation

(duration) ..... yrs. ..... mos. 1/2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 4/6/27

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clement B. Womac, M. D.

19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Abingdon County — DATE OF BURIAL June 11 1927

20 UNDERTAKER Howard K. McComas — ADDRESS Abingdon Md

INFORMATION should be carefully supplied. AGE, should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21008

CERTIFICATE OF DEATH.

66 ✓ E 21008

28-64

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 809 S. Sharp St. St. 28 Ward)

2-FULL NAME James M. Cruikshank.

(a) RESIDENCE NO. 3806 Hamilton Ave. St._____ Ward_____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs., ---- How long in U. S., If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male. | White. | Married. |

5a If married, widowed or divorced HUSBAND of Minnie Cruikshank.

6 DATE OF BIRTH (month, day, and year) September 23, 1873.

| 7 AGE. Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|
| 53 | 6 | 14 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer.

(b) General nature of industry, business, or establishment in which employed (or employer) Standard Sanitary

(c) Name of emptoyer Mfg. Co.

9 BIRTHPLACE (city or town)_____

(State or country) Shamokin, Pa.

PARENTS

10 NAME OF FATHER John Cruikshank.

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Pennsylvania.

12 MAIDEN NAME OF MOTHER Sarah -------

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Pennsylvania.

14 Informant Minnie Cruikshank. (wife)

(Address) 215 Cilburn Ave.

15 Filed_____, 19____ C. HAMILTON JONES, M.D.

Registrar

APR - 8 1927 Per

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism.

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) Otto M. Reinhardt (Coroner) M. D.

4/7, 1927 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ____ yrs., ____ mos., ____ ds. In the State ____ yrs., ____ mos., ____ ds.

Where was disease contracted, if not at place of death?_____

Former or usual residence_____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Date of Burial Apr 9 1927

20 UNDERTAKER Enoch Pratt Co. ADDRESS 1003 W. Balto St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—B.B.R.S.—400 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21009

## CERTIFICATE OF DEATH.

74-001

E 21009 Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 928 N. Stricker St., 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mazie Thompson

(a) Residence No. 928 N. Stricker St., Ward

(Usual place of abode) (If non resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, C.

5-~~Single~~, Married, ~~Widowed or Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Thompson

6-DATE OF BIRTH (month, day and year) 1891

7-AGE. 36 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). West Virginia

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Unknown

12-MAIDEN NAME OF MOTHER. Jane Allen

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

11- (Informant) Ella Brooks

(Address) 928 Stricker Street

APR 8 1927 Filed. HAMILTON JONES, M. D. Registrar.

Per

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4/17/27

17- I HEREBY CERTIFY, That I attended deceased from 4/11, 1927, to 4/17, 1927, that I last saw ~~her~~ alive on 4/17, 1927, and that death occurred, on the date stated above, at 7.15 P. M.

The CAUSE OF DEATH* was as follows:

Menengeal Apoplexy.

(Duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Trauma

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. M. Lawrence M. D.

, 19 (Address) 1232 W. Mosher St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19-PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL. |
|---|---|
| Mt. Auburn Cemetery | April 10 1, 1927 |
| 20-UNDERTAKER. | ADDRESS 322 |
| Mrs. Katie R. Williams | N. Schroeder St. |

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

20157.0. E 21010

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

44 E 21010

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 18-26 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Lund

(a) RESIDENCE NO. 930 N Saratoga St. City Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | Married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 43 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Virginia

(State or country)

PARENTS

10 NAME OF FATHER George Lund

11 BIRTHPLACE OF FATHER (city or town) Va

(State or country)

12 MAIDEN NAME OF MOTHER Ada —

13 BIRTHPLACE OF MOTHER (city or town) Va

(State or country)

14 Informant Records

(Address)

15 Filed APR. 8 1927 J. HAMPSON JONES, M. D. Registrar

Per K.C.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 7 1927

17

I HEREBY CERTIFY, That I attended deceased from Mar 28 1927 to Apr 7 1927.

that I last saw h. alive on Apr 7 1927.

and that death occurred, on the date stated above, at 6.30 P.M.

The CAUSE OF DEATH* was as follows)

Cancer of Stomach

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Pneumonia (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of Apr 1927

Was there an autopsy? No

What test confirmed diagnosis? Doctor

(Signed) Harvey G. Stinson, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery Date of Burial April 11 1927

20 UNDERTAKER By Wm. R. Williams ADDRESS 822 N. Edwards St

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

E 21011

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

129

E 21011

REGISTERED NO.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3019 Frederick Ave. St. 20-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John L. Tall

(a) RESIDENCE NO. 3019 Frederick Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lydia E. Tall

6 DATE OF BIRTH (month, day, and year) June 21, 1853

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|---|
| | 73 | 9 | 17/6 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Foreman

(c) Name of employer Tin Factory

9 BIRTHPLACE (city or town) Cambridge, (State or country) Md.

PARENTS

10 NAME OF FATHER William Tall

11 BIRTHPLACE OF FATHER (City or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Hester Lamb

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Lydia E. Tall

(Address) 3019 Frederick Ave.

15 Filed APR. 8 1927 C. Hampson Jones, M. D. Registrar

Per R.R.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7 1927

17 I HEREBY CERTIFY, That I attended deceased from January 1 1927 to April 7 1927

that I last saw him alive on April 7 1927

and that death occurred, on the date stated above, at 5.05 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Calculus Heart disease

Mitral regurgitation (duration) yrs. 3 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? yes

(Signed) Geo. M. Kieffer M. D.

April 8 1927 (Address) 2320 Bach. Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — Date of Burial April 10 1927

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21012

## CERTIFICATE OF DEATH.

E 21012

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospital Ward) 17-2

2-FULL NAME Rosie Jones

(a) RESIDENCE NO. 2553 Nunsen St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Wid

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: not known

6 DATE OF BIRTH (month, day, and year): not stated

| 7 AGE Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|
| 60 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER: Horace Jones

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Md

12 MAIDEN NAME OF MOTHER: Louise

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Virginia

14 Informant (Address) Hospital records

15 Filed....., 19 C. HAMPSON JONES, M. D. Registrar

APR - 8 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 April. 6, 1927

17 I HEREBY CERTIFY, That I attended deceased from 11-25, 1925 to 4-6, 1927

that I last saw him alive on 4-6- 1927

and that death occurred, on the date stated above, at 1:30 m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis, Generalized Osteosclerosis

(duration) Unknown

CONTRIBUTORY (Secondary) Lumbar Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms Signs

(Signed) Dr Bolgiano, M. D.

19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery Date of Burial April 8, 1927

UNDERTAKER: John M. Johnson ADDRESS 1259 Etting St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21013

E 21013

## CERTIFICATE OF DEATH

122-002

1-PLACE OF DEATH

City of BALTIMORE: (No. Univ Hospital St. 6-10 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest Ella

(a) RESIDENCE NO. 332 Patterson Park Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 Color or Race: W

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): June 1918

7 AGE: Years 8 Months 10 Days — IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of Industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) York Ville Ohio

(State or country)

PARENTS

10 NAME OF FATHER Sam Ella

11 BIRTHPLACE OF FATHER (City or town) Italy

(State or country)

12 MAIDEN NAME OF MOTHER Rose Fusi

13 BIRTHPLACE OF MOTHER (city or town) Italy

(State or country)

14 Informant Sam Ella

(Address)

15 Filed ..... 19 ..... C. HAMILTON JONES, M. D.

Per ..... Registrar

APR 8 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/8 1927

17 I HEREBY CERTIFY, That I attended deceased from 2/7 1927 to 4/8 1927

that I last saw h alive on 4/6 1927

and that death occurred, on the date stated above, at 10:15 A.m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of liver

Staph. septicemia

Otitis media

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial pneumonia

(duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted

If not at place of death? Home & Hospital

Did an operation precede death? Yes Date of 2/21/27

Was there an autopsy? Yes

What test confirmed diagnosis? Clinic & Laboratory

(Signed) C. K. Mallet M. D.

19 (Address) Univ Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: York Ville Ohio — Date of Burial: Apr. 9 1927

20 UNDERTAKER: Frank T. Pistone — ADDRESS: 2518 E. B. St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 21014

E 21014

38

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital) St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Miller

(a) RESIDENCE NO. 344 N. Bidle St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F Female

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb. 4, 1927

7 AGE: Years — Months: 2 — Days: 4 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 0

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Md.

PARENTS

10 NAME OF FATHER Benjamin Miller

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Md.

12 MAIDEN NAME OF MOTHER Gertrude Cromwell

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Md.

14 Informant C. H. Peckham

(Address) Johns Hopkins Hospital

15 Filed 1927 C. J. HAMPSON, JONES, M. D. (Registrar)

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 4 1927, to April 7 1927, that I last saw her alive on April 7 1927, and that death occurred, on the date stated above, at 8 00 A. m.

The CAUSE OF DEATH* was as follows:

Typhoides

(duration) yrs. mos. 03 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) C. H. Peckham, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Wm. of Balto Co. Md. Date of Burial Apr 8 1927

20 UNDERTAKER: W. D. Chatman ADDRESS Chocwin Md.

Per

NOTICE—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21015

## CERTIFICATE OF DEATH

45 E 21015

1-PLACE OF DEATH University Hospital REGISTERED NO.

City of BALTIMORE: (No. St. 16-67 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lottie Patterson

(a) RESIDENCE NO. 3100 Dennison St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Black

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1885

7 AGE: Years 42 Months Days IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto.

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Alec Williams

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Maryland

12 MAIDEN NAME OF MOTHER: Laura

13 BIRTHPLACE OF MOTHER (city or town):

(State or country)

14 Informant: Mrs. Lottie Patterson

(Address): 830 a Shaw.

15 Filed APR 8 1927 C. HAMPSON JONES M. D. Registrar

Per Rtk

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/6/27 19

17 I HEREBY CERTIFY, That I attended deceased from 4/4/27, 19..., to 4/6/27, 19...,

that I last saw her alive on 4/6/27, 19...,

and that death occurred, on the date stated above, at 9P.M.

The CAUSE OF DEATH* was as follows:

Generalized Carcinomatosis Primary in Mesenteric Cyst

(duration) one yrs. mos. da.

CONTRIBUTORY (Secondary): Cardiac Failure

(duration) yrs. mos. 3 da.

18 Where was disease contracted

If not at place of death? -

Did an operation precede death? - Date of -

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) G. E. Winstead, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Date of Burial April 9 1927

20 UNDERTAKER: R L Parham ADDRESS 1216 E. Shar[illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 21016

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21016

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1535 Hanover St. Ward) 23-32

Registered No. 89

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Debus

(a) Residence No. 1537 Hanover St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. 2 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE Mattie Debus

6-DATE OF BIRTH (month, day and year) Feb 5th 1874

7-AGE. 53 yrs. 2 mos. 0 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Engineer Stationary

(b) General nature of industry, business, or establishment in which employed (or employer) 030

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Louis Debus

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER Barbara Quenfelser

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto Md

14- (Informant) Mattie Debus

(Address) 1535 Hanover st

15- Filed APR 8 1927 C. HAMPSON JONES, M. D. Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 6/27

17- I HEREBY CERTIFY, That I attended deceased from April 1927 to April 6 1927

that I last saw him alive on April 4 1927

and that death occurred, on the date stated above, at 2.45 a.m.

The CAUSE OF DEATH* was as follows: Congestion Kidneys

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Dropsy

(Duration) yrs. mos. 15 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Hawkins M. D.

4/6 1927 (Address) 1535 Hanover st

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Balto Cem. DATE OF BURIAL. April 9th 1927

20-UNDERTAKER, E. Schlosman & Son ADDRESS 1037 Hanover st

R - 8 1927

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E21017

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1784 E 21017

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 7-9 Ward)

2-FULL NAME Susie Hunt-

(a) RESIDENCE NO. Gardner West Va St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Marvin

6 DATE OF BIRTH (month, day, and year) Sept 14/1887

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 40 | 7 | 24 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) West Va

(State or country)

PARENTS

10 NAME OF FATHER Isaac Fletcher

11 BIRTHPLACE OF FATHER (city or town) W. Va.

(State or country)

12 MAIDEN NAME OF MOTHER Elmira Colwell

13 BIRTHPLACE OF MOTHER (city or town) W. Va.

(State or country)

14 Informant Records

(Address) [illegible]

15 Filed _____, 19___ C. HAMPSON JONES, M. D.

Per _____ Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 8 1927

17

I HEREBY CERTIFY, That I attended deceased from Mar 27 1927, to Apr 8, 1927, that I last saw h.er alive on Apr. 8, 1927, and that death occurred, on the date stated above, at 2.25 p.m.

The CAUSE OF DEATH* was as follows:

Brain Tumor hypophyseal (Cancer)

(duration) 15 yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) _____

(duration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 4/1/27.

Was there an autopsy? yes

What test confirmed diagnosis? Operation and autopsy

(Signed) George E. Finney, M. D.

4/8/27 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bluefield W Va Date of Burial 4/8/27

20 UNDERTAKER Joseph Ahrens ADDRESS 22 Auray

CAUTION.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should give CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

R - 8 1927

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21018

## CERTIFICATE OF DEATH.

1827 E 21018

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH (a) Ward, City of BALTIMORE: (No. Alice Ann & Jefferson St., 5 Ward)

2-FULL NAME Unknown

(a) RESIDENCE NO. Unknown St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | Not known |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | about 35 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) —

(State or country)

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) —

(State or country) —

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) —

(State or country)

14 Informant .....

(Address) .....

Filed APR 8 1927 C. HAMPSON JONES, M. D.

Per RRH Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. - 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ..... yrs. ..... mos. 1 ds.

(Signed) C C Yates M. D.

(Coroner)

Apr. 19 27 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY. Date of Burial 19

20 UNDERTAKER Commissioner Health. ADDRESS APR 8 - 1927

THE METRICS

Tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be very important. See instructions on back of certificate. OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21019

## CERTIFICATE OF DEATH.

E 21019

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. City Jail St., 4-25-90 Ward)

2-FULL NAME James Murphy

(a) RESIDENCE NO. 723 W Lexington St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Md

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 66; Months; Days; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ?

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant

(Address)

15 Filed 1927 G. HAMPSON JONES, M. D. Registrar

1241

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/27 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Nat. dis. heart

Sudden (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs. ....mos. ....ds.

Apr 7, 1927 (Signed) [illegible], M. D. (Coroner)

(Address) 1099 Cary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death....yrs., ....mos., ....ds. In the State ....yrs., ....mos., ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 19

20 UNDERTAKER ADDRESS

Commissioner Health

APR 8 1927

UNIVERSITY OF MARYLAND
APR 8 1927
THE HISTORICAL

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

E 21020

# HEALTH DEPARTMENT—CITY OF BALTIMORE

162

E 21020

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Johns Hopkins Hospital.

City of BALTIMORE: (No. ____ St. 17-26 Ward)

REGISTERED NO. ____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Addison

(a) RESIDENCE NO. 617 Emma St. Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race Col Black

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 3, 1927

7 AGE — Years | Months | Days 2 1/2 | IF LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ____

(b) General nature of industry, business, or establishment in which employed (or employer) ____

(c) Name of employer ____

9 BIRTHPLACE (city or town) ____

(State or country) Md.

PARENTS

10 NAME OF FATHER Howard Jackson

11 BIRTHPLACE OF FATHER (city or town) ____

(State or country) Md.

12 MAIDEN NAME OF MOTHER Dorothy Mae Addison

13 BIRTHPLACE OF MOTHER (city or town) ____

(State or country) Md.

14 Informant J. K. Boerner + Mrs

(Address) Johns Hopkins Hospital

APR 8 1927 19 ____ C. HAMPSON JONES, M. D. Registrar

1243 Rec'd

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 19 27

17 I HEREBY CERTIFY, That I attended deceased from April 3, 1927, to April 5, 1927, that I last saw him alive on April 5, 1927, and that death occurred, on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Hemorrhagic disease of Newborn

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) ____

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted (If not at place of death) ____

Did an operation precede death? No Date of ____

Was there an autopsy? Yes

What test confirmed diagnosis? ____

(Signed) J. K. Boerner, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial APR 8 - 1927 19 ____

20 UNDERTAKER — ADDRESS Commissioner Health

JOHNS HOPKINS HOSPITAL

Per. ____

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# E 21021

## HEALTH DEPARTMENT—CITY OF BALTIMORE

43E 21021

## CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 3929 Cloverhill Rd St. 12-49 Ward)

2-FULL NAME Margaret Letitia Wilson

(a) RESIDENCE NO. 3929 Cloverhill Road St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: James B. Wilson

6 DATE OF BIRTH (month, day, and year): June 14 - 1854

7 AGE: Years 72 | Months 9 | Days 23 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town): Deal Island

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Andrew J. Brodshaw

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Maryland.

12 MAIDEN NAME OF MOTHER: Sarah E. Price

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Maryland.

14 Informant: W. B. Wilson

(Address): 3929 Cloverhill Road

15 Filed C. HAMPSON JONES, M. D. Registrar

APR 1927 Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 April - 7 - 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1925, to April 7, 1927, that I last saw h.. alive on April 7, 1927, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

I. Carcinoma of Sigmoid with Metastasis

(duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis.

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Nov. 1925.

Was there an autopsy? No.

What test confirmed diagnosis? Clinical & Pathological Examination

(Signed) E. H. Edmunds M. D.

4/7, 1927 (Address) 2144 Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Deal's Island Somerset Date of Burial 4/9 1927

20 UNDERTAKER to ma. ADDRESS 2016 Orleans St

Philip Herring

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 21022

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 21022

1-PLACE OF DEATH House in City, Yard in County

REGISTERED NO.

City of BALTIMORE: (No. 8 W. Maple Ave. (Overlea) St. 7-11-2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary D. Ahlers

(a) RESIDENCE NO. 8 W. Maple Ave (Overlea) St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George P. Ahlers

6 DATE OF BIRTH (month, day, and year) Oct. 11th. 1858

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 68 | 5 | 26 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER --- Rummell

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant George P. Ahlers

(Address) 8 W. Maple Ave (Overlea)

15 Filed ..... 19 ..... Registrar

By .....

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

April 7th. 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 2 nd 1926, to April 7th, 1927, that I last saw h.. alive on April 7th, 1927, and that death occurred, on the date stated above, at 2.40 A.m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 3 ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) Chas. F. Benson, M. D.

4/8, 1927 (Address) Overlea Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel Cem. Date of Burial: 4/9/27

20 UNDERTAKER: Philip Herwig ADDRESS 216 Orleans St.

APR 8 1927 C. HIMPSON JONES, M. D.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state DISEASE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 21023

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 21023

161-901

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1113 W. Lexington ST. 18-76 WARD)

2-FULL NAME Baby Boy Johnson

(a) RESIDENCE NO. 1113 W. Lexington ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of or) WIFE of: ——

6 DATE OF BIRTH (month, day, and year): March 22 '27

7 AGE

| Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|
| — | — | 14 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Warren Burton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: Eva Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: Eva Johnson

(Address): 1113 W. Lexington St.

15 Filed: APR 8 1927 Per. 19 C. HAMPSON GRAY, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 5 1927

17 I HEREBY CERTIFY, That I attended deceased from March 22 1927 to April 5 1927

that I last saw him alive on April 5 1927

and that death occurred, on the date stated above, at 11:30 p.m.

The CAUSE OF DEATH* was as follows:

Prematurity.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Marguerite B. Ballard M. D.

19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion cmtry

DATE OF BURIAL: apr 5 1927

20 UNDERTAKER: J. Leon Hall

ADDRESS: Dolphin

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

7-17-26—A Co.—200 Blks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21024

## CERTIFICATE OF DEATH

X 135

E 21024

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. 30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ulysses K. Haines

(a) RESIDENCE NO. Westminster St. Ward Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Ella M. Haines

6 DATE OF BIRTH (month, day, and year) Nov 26 1866.

| 7 AGE | Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.. |
|---|---|---|---|---|
| | 60 | 4 | 13 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) O'B

(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Maryland

PARENTS

10 NAME OF FATHER Ethanon Haines

11 BIRTHPLACE OF FATHER (City or town) .....
(State or country) Md.

12 MAIDEN NAME OF MOTHER Edith Kelly

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Md.

14 Informant Wife - Ella M. Haines
(Address) Westminster, Md.

15 Filed ..... 19.. C. HAMPSON JONES, M. D. Registrar

R - 8 1927 Per ARH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/8 1921

17 I HEREBY CERTIFY, That I attended deceased from 3/18, 1921 to 4/8, 1921 that I last saw h.. alive on 4/8, 1921 and that death occurred, on the date stated above, at 1.30 P.m.

The CAUSE OF DEATH* was as follows:

Uremia, Septicemia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Prostatic hypertrophy, Infection, Cystitis, Retention

(duration) 2 yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Westminster Md,

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood culture

(Signed) H. S. Anderson M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Baltimore, Md. Dulaney Cemetery. | Sept 21, 1927 |

20 UNDERTAKER C. M. Watts. ADDRESS Mayfield, Md.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21025

## CERTIFICATE OF DEATH.

90 E 21025

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 201 Atlantic Ave St. 4-45 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Mary Lyness

(a) RESIDENCE NO. 201 Atlantic Ave St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: A. J. Lyness

6 DATE OF BIRTH (month, day, and year): Feb 24 1869

7 AGE — Years: 58 — Months: 1 — Days: 14 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER: Wm F Wiseman

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER: Mary Hollen

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Germany

14 Interment

(Address) 201 Atlantic Ave.

15 Filed C. HAMPSON JONES, M. D. Registrar

Per RPB

8 1927

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

April 7 1927.

17 I HEREBY CERTIFY, That I attended deceased from April 2 19 27 to April 7 19 27

that I last saw h.... alive on April 7 19 27

and that death occurred, on the date stated above, at 5-20 m.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration

Bronchial Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Myocarditis

Endocarditis

(duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem. — Date of Burial 4/9/27 19

20 UNDERTAKER: C. Vernon Lemmon — ADDRESS 501 E 22 St

Upon should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 21026

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21026

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 418 W. Lexington St. WARD) Volunteers of America Hospital

REGISTERED NO. 95-72

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ozzie Chambers

(a) RESIDENCE NO. 2208 Washington Boulevard ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth Chambers

6 DATE OF BIRTH (month, day, and year): Apr 28-1870

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| ~~F~~ | 56 | 11 | 9 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Steam Fitter

(b) General nature of industry, business, or establishment in which employed (or employer): Building

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Queens Anne Co Md

PARENTS

10 NAME OF FATHER: James Chambers

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Annie Tires

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs Elizabeth Munck

(Address) 2500 Emerson Ave

15 Filed: APR 8 1927

C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 6th 1927.

17 I HEREBY CERTIFY, That I attended deceased from Feby 23, 1927. to April 6th, 1927. that I last saw him alive on April 6th, 1927, and that death occurred, on the date stated above, at 1159 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Oesophagus.

(duration) yrs. — mos. — ds.

CONTRIBUTORY (Secondary): Stricture of Oesophagus

(duration) 6 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of. —

Was there an autopsy? —

What test confirmed diagnosis? Microscopic

(Signed) Karl J. Steinmuller, M. D.

, 19 (Address) 321 N. Carrollton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Centreville, Md

DATE OF BURIAL: Apr 9 1927

20 UNDERTAKER: H. J. Tuckner, Asst

ADDRESS: Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

E 21027

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21027

## CERTIFICATE OF DEATH.

129

12-50

1-PLACE OF DEATH

Registered No.

City of BALTIMORE: (No. 2415 St Paul St. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Mehring

(a) Residence No. 2415 St. Paul St St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? 46 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: white

5-Single, Married, Widowed or Divorced (Write the word.): single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ------

6-DATE OF BIRTH (month, day and year) Sept. 29. 1856

7-AGE: 70 yrs. 6 mos. 8 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: milk business

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer: self

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS

10-NAME OF FATHER, Carl Mehring

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Sophia Francke

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-(Informant) Mrs. J. S. Briscoe

(Address) 2415 St. Paul St.

15-Filed 1927 C. HAMPSON JONES, M. D. Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 7 1927

17- I HEREBY CERTIFY, That I attended deceased from Nov. 19 27 to Apr. 7. 19 27

that I last saw h— alive on Apr. 5. 19 27

and that death occurred, on the date stated above, at 7:50 P m.

The CAUSE OF DEATH* was as follows:

Aortic & Mitral Regurgitation

Cardiac Hypertrophy. Interstitial Nephritis (Duration) 4½ yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam + Laboratory

(Signed) A. T. Reis, M. D.

Apr. 8. 1927 (Address) 24 E Mt Vernon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, First German Evangelical Cemetery — DATE OF BURIAL, April 9. 1927

20-UNDERTAKER, Hughes & Jones — ADDRESS 434 N. Broadway

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

E 21028

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

74001 E 21028

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 119 S. Broadway 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME TJARK B. SUSEMIHL

(a) RESIDENCE NO. 119 S. Broadway St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Christiana Susemihl

6 DATE OF BIRTH (month, day, and year) Oct. 22. 1847

| 7 AGE | Years | Months | Days | IF LESS than 1 day ____ hrs. or ____ min.. |
|---|---|---|---|---|
| | 79 | 5 | 15 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dyer + Cleaner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Holland

(State or country)

PARENTS

10 NAME OF FATHER Heinrich Susemihl

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Holland

12 MAIDEN NAME OF MOTHER Albertina Debose

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs. Christiana Susemihl

(Address) 119 S. Broadway

15 Filed APR 8 1927 19 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr 4 1927, to Apr 6 1927,

that I last saw h[e] alive on Apr 6 1927,

and that death occurred, on the date stated above, at 4 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) G H Meyer M. D.

4/8, 19 27 (Address) 15 N E 3 Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery — Date of Burial Apr. 9 1927

20 UNDERTAKER Henry Sader & Sons Inc — ADDRESS 1710 Fleet St.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. –7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21029

## CERTIFICATE OF DEATH

E 21029

1-PLACE OF DEATH Union Memorial Hospital REGISTERED NO.

City of BALTIMORE: (No. 33rd & Calvert St., 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. May S. Kennedy

(a) RESIDENCE NO. 1524 Bolton St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. 4 mos. 8 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 7-28-1864

7 AGE: Years 63 62 Months 8 Days 10 11

IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): (State or country) Maryland

PARENTS

10 NAME OF FATHER: Edmund Kennedy

11 BIRTHPLACE OF FATHER (City or town): (State or country) Virginia

12 MAIDEN NAME OF MOTHER: Julia Paca

13 BIRTHPLACE OF MOTHER (city or town): (State or country) Maryland

14 Informant: Nicholson (Address) 2100 Elsinore Ln

15 Filed ... 19.. C. HARRISON JONES, M. D. Registrar

R - 8 1927

Per RKH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

4-8-1927

17 I HEREBY CERTIFY, That I attended deceased from 4-1, 1927, to 4-8, 1927, that I last saw her alive on 4-8, 1927, and that death occurred, on the date stated above, at 1:50 P.m.

The CAUSE OF DEATH* was as follows:

Hyperthyroidism

(duration) 3 yrs. 4 mos 8 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) ... yrs. ... mos 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 4-4-27

Was there an autopsy? Yes

What test confirmed diagnosis? Yes

(Signed) L. C. Spencer, M. D.

, 19 (Address) L. M. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Charles Town W Va — Date of Burial: Sept 9 1927

20 UNDERTAKER: Henry Hjerl & Co — ADDRESS: Greenmount Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 21030

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21030

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 746 N. Fulton Ave. St.) 6-22 (WARD) 29

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace Ann Yewell

(a) RESIDENCE No. 746 N. Fulton Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| Female | White | Widow |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Mos Yewell

6 DATE OF BIRTH (month, day, and year) Dec. 25 1857

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 69 | 3 | 13 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Newburgh N.Y.

PARENTS

10 NAME OF FATHER Geo. James Staigg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mass.

12 MAIDEN NAME OF MOTHER Eliza Little

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mass.

14 Informant Mrs. N. D. Lavery

(Address) 746 N. Fulton Ave.

15 Filed 8 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 7 1927

17

I HEREBY CERTIFY, That I attended deceased from June 18- 1922 to April 7- 1927-

that I last saw h[illegible] alive on April 6- 1927-

and that death occurred, on the date stated above, at 12.45 a.m.

The CAUSE OF DEATH* was as follows:

Cystal Hemorrhage
Chronic Interstitial Nephritis
Arterio Sclerosis.

(duration) 4 yrs. 9 mos. 19 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Usual laboratory.

(Signed) [signature], M. D.

Apr 8, 1927 (Address) 2125 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cem. DATE OF BURIAL Apr 9 1927

20 UNDERTAKER Wm. F. Kuerbis Sons ADDRESS North Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21031

## CERTIFICATE OF DEATH

159-002

E 21031

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1104 Sargent St. (Ward) 21-29

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irene Roeder

(a) RESIDENCE NO. 1104 Sargent St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Fem | Wh | Sngl |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4/7/27.

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min.. |
|---|---|---|---|---|
| | | | 1 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md

(State or country)

PARENTS

10 NAME OF FATHER — Wm C. Roeder

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Irene Ireland.

13 BIRTHPLACE OF MOTHER (City or town)

(State or country) Balto Md

14 Informant — Wm C Roeder

(Address) 1104 Sargent St

15 Filed 8 1927 C. HAMPSON JONES, M. D.

Per RPO Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/8 19 27

17 I HEREBY CERTIFY, That I attended deceased from 4/7, 19 27, to 4/8, 19 27,

that I last saw her alive on 4/7, 19 27,

and that death occurred, on the date stated above, at 10:30 P. m.

The CAUSE OF DEATH* was as follows:

Morbus Cordis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Incomplete Closure of Interauric. Septi

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C Mitchell, M. D.

4/8, 1927 (Address) 1279 Hilland Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

Date of Burial Apr. 9 1927

20 UNDERTAKER Joseph B Cook

ADDRESS 1003 N. Calvert St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 21032

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

100-001.

E 21032

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St. 743 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Bregel.

(a) RESIDENCE NO. 808 Hunter St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 78 | — | — | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Jacob Bregel

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant BALTIMORE CITY HOSPITALS

(Address) [redacted] Baltimore

15 Filed 8 1927, 19 C. HAMPSON JONES, M. D.

Per Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/7 1927.

17 I HEREBY CERTIFY, That I attended deceased from Feb. 21, 1922 to April 7, 1927

that I last saw him alive on April 7, 1927

and that death occurred, on the date stated above, at 5:00 P.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? general + Subs.

(Signed) C. Hampson Jones, M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery Date of Burial 4/9 1927

20 UNDERTAKER Chas F. Kraus & Son ADDRESS 1811 W. Mt Royal Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21033

E 21033

## CERTIFICATE OF DEATH.

REGISTERED NO. 151

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (~~JOHNS HOPKINS HOSPITAL~~ 12-50 Ward)

2-FULL NAME A. Wade Thomley

(a) RESIDENCE NO. 2430 Freemont St. Ave. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Thornberg

6 DATE OF BIRTH (month, day, and year) Unknown

| 7 AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 63 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Piece Goods Man

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) Md —

(State or country)

PARENTS

10 NAME OF FATHER Isaac Thornley

11 BIRTHPLACE OF FATHER (city or town) Ches.

(State or country)

12 MAIDEN NAME OF MOTHER Susie McLinder

13 BIRTHPLACE OF MOTHER (city or town) Md —

(State or country)

14 Informant Friends

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Registrar

C. HAMILTON JONES, M. D.

1927 Fee: Free

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 8 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 15, 1927, to Apr 8, 1927, that I last saw h~~im~~ alive on Apr 8, 1927, and that death occurred, on the date stated above, at 0558 m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Scleroderma pachydactyla Raynauds Disease

(duration) 10 yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Milton Sheen, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery Date of Burial 4/11 1927

20 UNDERTAKER Chas S. Wane & Son ADDRESS 1181 W. Royal Ave

Don should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21034

## CERTIFICATE OF DEATH.

15 2003 E 21034

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Children's Hospital School St. 13-51 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ann Marie Crowley

(Residence in Baltimore: No. 4019 Wilson Ave. St.: 2 yrs., mos. 14 ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

| 3-SEX. | 4-COLOR OR RACE. | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) |
|---|---|---|
| Female | White | Sgl |

6-DATE OF BIRTH. March (Month) 25 (Day), 1925 (Year).

7-AGE, 2 yrs. — mos. 14 ds. 12

If LESS than 1 day, ....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: child
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. John J. Crowley

11-BIRTHPLACE OF FATHER (State or Country). Boston, Mass.

12-MAIDEN NAME OF MOTHER. Agnes Esther Healy

13-BIRTHPLACE OF MOTHER (State or Country). Irvington on the Hudson New York.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. John Crowley

(Address) 4019 Wilson Ave

15-

Filed....., 191....

Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. April (Month) 7th (Day), 1927 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Apr. 4th 1927, to Apr. 7th 1927, that I saw her alive on April 7th 1927, and that death occurred, on the date stated above, at 12.15 m.

The CAUSE OF DEATH* was as follows:

Post operative shock

(Duration) ....yrs. ....mos. 6 hrs ds.

CONTRIBUTORY (Secondary) Congenital dilatation hrt. ??

(Duration) life yrs. mos. 14 ds.

(Signed) Harold R. Bohlman M. D.

April 7, 1927 (Address) Children Hospital School

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 4 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? 4 years at Child. Hosp.

Former or usual residence 4019 Wilson Ave. Balto. Md

19-PLACE OF BURIAL OR REMOVAL. Cathedral Cemetery

DATE OF BURIAL. 4/9/, 1927

20-UNDERTAKER Chas. P. Maus & Son

ADDRESS 1107 W. Royal Ave

important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21035 — E 21035

## CERTIFICATE OF DEATH.

167-001

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 644 Portland St. Ward 22-30)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John C Mc Kenney

(a) RESIDENCE NO. 644 Portland St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| M | W | married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Howard Mc Kenney Eng

6 DATE OF BIRTH (month, day, and year) July 4 1879

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 47 | 8 | 24 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of indstry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Edwin Barker

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Edith Schofield

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Howard Mc Kenney

(Address) 644 Portland St

1927 C. HAMPSON JONES, M. D. Register

Per ACB

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/7 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Hemorrhage along Rt Coronary Thrombosis

Contributory yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Edmund A Gaither M. D.
(Coroner)

, 19 27 (Address) 3325 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Western Cem - April 9. 1927

20 UNDERTAKER — ADDRESS

Mrs Ann H. Pumphrey Sons 847 Hollins St

OBSTETRICAL ATTENDANT'S CERTIFICATE OF BIRTH. Fill out this certificate if you attended the birth. Write plainly with pen and ink. Use no abbreviations. Be careful and prompt in answering questions. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21036

## CERTIFICATE OF DEATH.

185 E 21036

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. approaching 1 St. Jo. Hosp. St., 8-17 Ward)

2-FULL NAME Frank M. Ernest Schmidt

(a) RESIDENCE NO. 1108 Mulberry St., _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| male | white | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 1852

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 44 | 4 | 11 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Eng. Steam Fitter

(b) General nature of industry, business, or establishment in which employed (or employer) Boiler

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Approaching

PARENTS

10 NAME OF FATHER Jno Schmidt

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Germany

12 MAIDEN NAME OF MOTHER Ruth Hoffman

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Germany

14 Informant Frank Schmidt

(Address) 1108 Mulberry

15 1927 C. HAMPSON JONES, M. D. Registrar

Per _____

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 7 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract. Skull — caused by accidentally falling from Cabin of hoist. Am Sugar Ref.

CONTRIBUTORY (Secondary) (duration) Hidden yrs. mos. ds.

(duration) ____ yrs. ____ mos. ____ ds.

Apr 9 (Signed) [illegible] M. D.

(Coroner)

1927 (Address) 1639 Ruxton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. Date of Burial Apr. 11 1927

20 UNDERTAKER Zirkler + Zirkler ADDRESS 1739 E Eager St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Eks.

E 21037

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21037

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE, (No. 1018 Sterling St. 10-14 Ward) 101

Registered No.

2-FULL NAME Laurence Patton Hampson

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 1018 Sterling St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced, (Write the word) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Feb. 20, 1926

7-AGE 1 yrs. 1 mos. 18 ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md

PARENTS.

10-NAME OF FATHER Edward Patton

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country), Md

12-MAIDEN NAME OF MOTHER Sarah Thompson

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country) Md

14-(Informant) Sarah Thompson

(Address) 1018 Sterling St

15-(Filed) 9 1927 C. HAMPSON JONES, M. D. Registrar.

Per —

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr. 8, 1927

17-I HEREBY CERTIFY, That I attended deceased from Apr 4, 1927 to Apr 7, 1927

that I last saw h— alive on Apr 7, 1927

and that death occurred on the date stated above, at 6:45 P.M.

The CAUSE OF DEATH was as follows:

Lobar Pneumonia (Acute)

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) P. Garland Chenoweth M. D.

1927 (Address) 1534 E. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Laurel cemetery DATE OF BURIAL. April 9th 1927

20-UNDERTAKER. Mr R A Elliott ADDRESS 1725 Ashland Ave

Be plain, write so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 21038

# HEALTH DEPARTMENT—CITY OF BALTIMORE.

## CERTIFICATE OF DEATH.

001
100 E 21038

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 1731 Jackson ST. 24-34 WARD

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John LeRoy Jox

(a) RESIDENCE (Usual place of abode) No. 1731 Jackson ST. WARD

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds. (If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 14/25

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 1 | 6 | 25 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: George H. Jox

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Co.

12 MAIDEN NAME OF MOTHER: Estella E Sawyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): North Carolina

14 Informant (Address): George H. Jox 1731 Jackson St

15 Filed . 19 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 9 1927

17 I HEREBY CERTIFY, That I attended deceased from March 25, 1927, to April 9, 1927, that I last saw h m alive on April 8, 1927, and that death occurred, on the date stated above, at 5:30 a m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Edward Jones, M. D.

4-9, 1927. (Address) 107 East Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pleasant Hill Cemetery DATE OF BURIAL: April 1927

20 UNDERTAKER: William Cost ADDRESS: 502 E North Ave

TION is very important See instructions on back of certificates.

R 9 1927

Spec.—1-10-21—M&T—1500 Blks.

E 21039

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21039

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Maryland General Hospital

REGISTERED NO. 90

CITY OF BALTIMORE: (No. 22 St. 33 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Fruehauger

(a) RESIDENCE NO. 417 E. Hamburg St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Emma Jean Fruehauger

6 DATE OF BIRTH (month, day, and year): 9/3/1891

7 AGE: Years 35 Months 7 Days 4 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Foreman.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Geo W Fruehauger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Margaret Burns

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland.

14 Informant (Address): Hospital Record.

15 Filed 9 1927 C. HAMPSON JONES, M. D. Registrar

Per RCH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/7 1927

17 I HEREBY CERTIFY, That I attended deceased from 3/13/27, 19 , to 4/7, 19 27.

that I last saw h/ alive on 4/7, 19 27.

and that death occurred, on the date stated above, at 2:15 P m.

The CAUSE OF DEATH* was as follows: Chronic myocarditis + Endocarditis

Cardio vascular disease ?

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno A Hamilton M. D.

, 19 (Address) Md Gen Hospt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill

DATE OF BURIAL: 4/11 1927

20 UNDERTAKER: Margaret J. Flynn

ADDRESS: 1422 W. Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21040 E 21040

## CERTIFICATE OF DEATH.

111-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Md. Gen. Hospital (ST.) 1127 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Meehan

(a) RESIDENCE NO. 801 Hamilton Terrace St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Divorced.

5a If married, widowed, or divorced (or) WIFE of: J. P. Meehan

6 DATE OF BIRTH (month, day, and year): Feb 3 1891

7 AGE — Years: 36 — Months: 2 — Days: 5 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Wolfgang Seibold

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Brehan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Hosp. Record.

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/8 1927

17 I HEREBY CERTIFY, That I attended deceased from 4/4 1927 to 4/8 1927

that I last saw her alive on 4/8/27

and that death occurred, on the date stated above, at 3:10 a. m.

The CAUSE OF DEATH* was as follows:

Pyloric Ulcer -

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary): Shock. Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 4/7/27

Was there an autopsy? No.

What test confirmed diagnosis? Operation

(Signed) Jno. A. Hampton Wilson, M. D.

1927 (Address) 1 East Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: 4/11 1927

20 UNDERTAKER: Margaret E. Flynn

ADDRESS: 1011 Light

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21041

## CERTIFICATE OF DEATH.

66 ✓

E 21041

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1106 Hanover St. 22-31 St. (Ward)

2-FULL NAME Albert H. Houck.

(a) RESIDENCE NO. 1106 Hanover St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 0 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male. | White. | Single. |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) March 17° 1872

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 55 | 0 | 20 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Soldier.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Casper Hauck.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Christina Heil.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany.

14 Informant Dora Leutner. (niece)

(Address) 308 Lynchurst Ave.

15 Filed ..... 19 .. C. HARRISON JONES, M.D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Leonhardt M.D. (Coroner)

4/8. 1927 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Com. Date of Burial 4/9 1927

20 UNDERTAKER Margaret S. Flynn ADDRESS 1422 Light St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

E 21042

# HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 ✓ E 21042

## CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 600 Grantley St. 16-67 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo. M. Strohmer

(a) RESIDENCE NO. 600 Grantley St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 11 mos. 7 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 1 1858

7 AGE 64 Years 11 Months 7 Days IF LESS than 1 day ____ hrs. or ____ min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md

(State or country)

PARENTS

10 NAME OF FATHER George M Strohmer

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Rosalba S Strohmer

(Address) 600 Grantley St

Filed APR 9 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8th 1927 19

17 I HEREBY CERTIFY, That I attended deceased from April 6th 1927, to April 8th 1927.

that I last saw him alive on April 7th 1927.

and that death occurred, on the date stated above, at 5.30 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Herbert F Stellman, M. D.

, 19 (Address) 6 East Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial |
|---|---|
| Holy Redeemer | Apr 11 1927 |
| 20 UNDERTAKER Geo J Smith | ADDRESS 153 Hollins |

(Physician should be careefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.)

Spec.—12-6-25—A Co.—200 Bks.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 21043

## CERTIFICATE OF DEATH.

E 21043

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. East City Hospital 23-31 Ward)

2-FULL NAME James E Smith

(a) RESIDENCE NO. 1004 E. Eutaw St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced. (write the word) |
|---|---|---|
| M | Col. | Single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1885

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 44 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pool porter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland

(State or country)

PARENTS

10 NAME OF FATHER Osbury Smith

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Maria

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Maggie Hudson

(Address) 1004 E Eutaw St

15 Filed C. HAMPSON JONES, M. D. Registrar

Per ACH

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April. 6, 1927

17

I HEREBY CERTIFY, That I attended deceased from Mch. 29, 1927, to April. 6, 1927, that I last saw him alive on April. 6, 1927, and that death occurred, on the date stated above, at 1130 a m.

The CAUSE OF DEATH* was as follows: Cellulitis of Right foot & leg — (duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Lymphangioma (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of Mch. 29, 1927

Was there an autopsy? no

What test confirmed diagnosis? Clinical Signs

(Signed) E. Blizard, M. D.

, 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bristol Calvert Co Md Date of Burial April 10 1927

20 UNDERTAKER J. H. Brown's Son ADDRESS 158 W. Monument

Spec.—1-10-21—M&T—1500 Bks.

E 21044

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21044

## CERTIFICATE OF DEATH.

122-901

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 582 Presstman ST. (or) 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Lewis

(a) RESIDENCE NO. 582 Presstman ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | Colored | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Grace Lewis

6 DATE OF BIRTH (month, day, and year) Dec 4, 1859

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 67 | 3 | 12 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Restaurant Cook

(b) General nature of industry, business, or establishment in which employed (or employer) Cooking 021

(c) Name of employer Self

9 BIRTHPLACE (city or town) Va

(State or country)

PARENTS

10 NAME OF FATHER Zachary Lewis

11 BIRTHPLACE OF FATHER (city or town) Va

(State or country)

12 MAIDEN NAME OF MOTHER Mary Coburn 4/7

13 BIRTHPLACE OF MOTHER (city or town) Va

(State or country)

14 Informant Grace Lewis

(Address) 582 Presstman St

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan 20, 1927 to April 6, 1927

that I last saw h— alive on April 6, 1927

and that death occurred, on the date stated above, at 6.20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Diffuse Nephritis 6 mos ds.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Hypostatic Congestion 1 yrs. mos. ds.

(duration)

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Wm A Wright, M. D.

(Address) 1209 Presstman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cemetery

DATE OF BURIAL April 11 1927

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1510 Presstman St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 21045

# HEALTH DEPARTMENT—CITY OF BALTIMORE

10-003

E 21045

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital S. 10 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie A. Pfeiffer

(a) RESIDENCE NO. 15 N Port St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Female | White | Single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 5, 1923

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs or min. |
|---|---|---|---|---|
| | 3 | 4 | 23 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Aloysius J. Pfeiffer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Denmark

12 MAIDEN NAME OF MOTHER Mary A Robel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mrs. Mary Pfeiffer
(Address) 15 N Port St

15 Filed 9 1927 C. HAMPSON JONES, M. D. Registrar

Form

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 1927

17

I HEREBY CERTIFY, That I attended deceased from March 31, 1927, to April 8, 1927.

that I last saw her alive on April 8, 1927

and that death occurred, on the date stated above, at 11.20 a m.

The CAUSE OF DEATH* was as follows:

Nasal Tonsillar & Pharyngeal Diphtheria

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Pos K-L. Cult.

(Signed) Myron G. Zull, M. D.

, 19 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Holy Redeemer | April 9 1927 |
| 20 UNDERTAKER | ADDRESS |
| Frank Enoch Son | 1906 Eastern Ave |

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 21046

E 21046

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Balto Gen Hosp 4-20 · WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Minnie Matthews

(a) RESIDENCE NO. 859 W. North Ave · WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

wife

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Morris Matthews

6 DATE OF BIRTH (month, day, and year): Oct 5-1876

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 50 | 6 | 1 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Isaac Pines

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Rebecca Bornstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Morris Matthews

(Address): 859 W. North Ave

15 Filed APR 10 1927 19 By C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/9 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 30, 1926, to April 9, 1927, that I last saw her alive on April 9, 1927 and that death occurred, on the date stated above, at 5.15 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) One year

CONTRIBUTORY (Secondary) none (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Clin Exam

What test confirmed diagnosis?

(Signed) Louis F. Lavy, M. D.

4/9, 1927 (Address) W. Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Hebrew Cem

DATE OF BURIAL: 15 April 1927

20 UNDERTAKER: J. Ahrens Co.

ADDRESS: 3314 Reisterstown Rd

TION is very important See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

Anna M Woolmer.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21047

## CERTIFICATE OF DEATH.

15-22 188-983

E 21047

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. _____ Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna M Woolmer

(a) RESIDENCE NO. 1317 N. Gilmor St St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. ___ mos. ___ ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 Color or Race | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | white | single |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) Aug 30/1900

| 7 AGE | Years | Months | Days | IF LESS than 1 day.....hrs. or.....min. |
|---|---|---|---|---|
| | 26 | 7 | 9 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stock clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Balto., Md

PARENTS

10 NAME OF FATHER James R. Woolmer

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Balto., Md

12 MAIDEN NAME OF MOTHER Eliz. C. Ament

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Balto., Md.

14 Informant Mr. James R. Woolmer

(Address) 1317 N. Gilmor St

Filed APR 10 1927 C. HAMILTON JONES, M. D. Registrar

Per _____

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above. Accidental

The CAUSE OF DEATH* was as follows: injury to spinal cord between 6th & 7th Vertebra., (Autopsy at Hopkin (Auto. accident nr Shrewsbury Pa. Mar 27/27) (duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) _____ (duration) ___ yrs. ___ mos. ___ ds.

(Signed) J. H. Oaks M. D.

(Coroner)

4/9/27 (Address) 506 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery Date of Burial April 12 1927

20 UNDERTAKER Henry Hoeck Son ADDRESS 1301 E Eager St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21048

## CERTIFICATE OF DEATH.

101-001 J

E 21048 REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 909 Bucks Lane St. 25-63 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Charles Wenzel

(a) RESIDENCE NO. 909 Bucks Lane St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. 7 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (~~or WIFE~~) of Louisa Wenzel

6 DATE OF BIRTH (month, day, and year) Aug 26, 1853

| 7 AGE | Years | Months | Days | IF LESS than 1 day....hrs. or....min. |
|---|---|---|---|---|
| | 73 | 7 | 12 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work TINNER 054

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer United Rwg Co

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Henry Wenzel

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Kate Wolfang

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germ

14 Informant Louisa Wenzel

(Address) 909 Bucks Lane

15 Filed APR 10 1927 C. HAMPSON JONES, M. D. Registrar

Per RK

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 8, 1927

17

I HEREBY CERTIFY, That I attended deceased from April 2 1927, to April 8, 1927,

that I last saw him alive on April 8, 1927,

and that death occurred, on the date stated above, at 8 20 p m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted —

If not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Charles J. Wells, M. D.

, 19 (Address) 5242 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery Apl 11 1927

20 UNDERTAKER: Harry W. Eblen ADDRESS 1944 W. Mulberry

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

Schlabecker

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 21049

## CERTIFICATE OF DEATH.

129

E 21049

1-PLACE OF DEATH

City of BALTIMORE: (No. 608 W. Cross 21-29 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Schlabecker

(a) Residence No. 608 W. Cross St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John Schlabecker

6-DATE OF BIRTH (month, day and year) June 27th 1846

7-AGE. 80 yrs. 11 mos. 11 ds.

If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED:

(a) Trade, profession, or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS:

10-NAME OF FATHER Conrad Finker

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER Margaret Liefeld

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14-

(Informant) Katie Rutland

(Address) 608 W. Cross st

15-

(Filed) APR 10 1927 192

C. HAMPSON JONES, M. D.

Per

Registrar

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 4/6/27

17- I HEREBY CERTIFY, That I attended deceased from June 15 1927 to April 6 1927 that I last saw h[illegible] alive on April 7 1927 and that death occurred, on the date stated above, at 6.30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical & x.

(Signed) J. M. Lemmerman M. D

4/6 1927 (Address) 126 N. Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cedar Hill Cem. DATE OF BURIAL. April 11th 1927

20-UNDERTAKER. E. Schlosman & Son ADDRESS 1034 Hanover st

Instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 21050

E 21050

PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) 0739 York Rd (St.) 27-48 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Spencer

(a) RESIDENCE NO. 0739 York Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 2 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Male | White | Married |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Spencer

6 DATE OF BIRTH (month, day, and year) Jan 13 1864

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 63 | 2 | 26 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer) Leather work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm H Spencer

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Elizabeth B Nailor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Joseph M Spencer (Address) 2104 Guilford

15 Filed APR 10 1927 C. HAMPTON JONES, M. D. Registrar

By LM

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1926 to April 8, 1927, that I last saw he alive on April 8, 1927 and that death occurred, on the date stated above, at 3.20 P m.

The CAUSE OF DEATH* was as follows:

Intestinal Enteritis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Examination Clinical

(Signed) Alan I Lenman M. D.

April 9, 1927 (Address) 11 W Patterson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery

DATE OF BURIAL April 11 1927

UNDERTAKER Henry Lentz

ADDRESS 1203 Broadway

THIS SECTION is very important See instructions on back of certificates.

CITY HALL
BALTIMORE 2 MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

# CERTIFICATION

THIS IS TO CERTIFY THAT ON THIS 13th DAY OF April
OF 1965 THE MICROPHOTOGRAPHS APPEARING
HEREIN STARTING WITH #E 17561 JAN. 5, 1927 AND
ENDING WITH #E 21050 - April 10 1927 ARE ACCURATE AND COMPLETE REPRODUCTIONS OF THE
RECORDS OF THE DEPARTMENT OF Health
BUREAU OF Vital Statistics AS DELIVERED
IN THE REGULAR COURSE OF BUSINESS FOR
PHOTOGRAPHING, AND THAT:

TO THE BEST OF MY KNOWLEDGE THE MICROFILM
MEETS THE REQUIREMENTS OF THE NATIONAL BUREAU
OF STANDARDS FOR PERMANENT MICROPHOTOGRAPHIC
COPY.

CAMERA OPERATOR: D McFaul

CITY OF BALTIMORE

1797

# END OF REEL